Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item per doc g900 2-19-10 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 6 1. Decedent's Name (First, Middle, Last) Month 0700 M **Physician** 2010 Margaret Louise Jefferson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Avenue Balto
7. Age (In yrs. last birthday) If Under I Year 2901 E. Strathmore
5. Social Security Number 6. Sex Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-17-1942 **Funeral** Months Days Hours Min 1 □ M 2**X**□ F Yrs. MD 67 Director 215-40-2380 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Expansion of the conflict at 1 X Yes 2 □ No Director Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number US 21206 6050 Moravia Park Drive Funeral 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Important: If fem 27 is marked other the any Injury or other traumer. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2√XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Meridian Homewood Nursing Assistant llth grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Howard Beatrice Pankey ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Grand 1512 Waverly Way Balto, MD 21239 Tiffany Howard- daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 2-18-2010 Balto, MD March East F/H 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Balto, MD 21202 1101 E. North Avenue 1/ 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final espira ton week Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Hypertension Examiner ulwararu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) vision of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 DNo 9 ☐ Unknown 5 Other (specify) After this certificate has been signed by the tuneral director, page 2 should be detached it 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 DNo 24a. Was an autopsy performed? 1 Yes 2 2000 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 25ther's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To PLace 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Assided 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □ No Living after death.

Director: / 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Latelans D45757 4940 Eosker Ave Beldinne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rey State Registrar

DHMH 17 Rev 1/2001

Physician/ Medical Examiner or Attending Physician: The law requires that the death certificate be executed Box 68760

Physician/

Medical

Director

Completed by Funeral

Be

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Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transi signed by the a cate has been sig page 2 should b certificate E Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificieted filled in by the funeral director,

Division of Vital Records, P.O.

Examiner resulting in death) Last Physician/Medical IF FEMALE 23b, Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş Completed 25. Was case referred to medical Be examiner? မှ Certificate: 27. Manner of Death 1 Natural (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending M Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 1 Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

29c. License numbe

4001

29d. Date signed (Month, Day, Year)

2010

21161

State Registrar 6535

29b. Signature and title of certifier

30. Name and address of person who completed cause of de-

North

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within 24 hor To the Fune completed fi

ath (Item 23a) (Type, Print)

57

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1,20 GM **Physician** 10 9 1000 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner fructe Kaven Birthplace (State or Foreign Country) 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Year) Hours Months Days 061-36-6813 1 □**M**M 2 □ F 84 25 MD 14 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, it a "Modical Examinat must be notified at 1 ☐ Yes 2 XNo Director Baltimore Glen Arm MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21057 U.S.A. 12816 Kanes Road Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 2 Yes, Give 2 No 1 □ Yes 2 □ Xio Specify: Black Specify: ģ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 th and Mental Hygiene.
7 Is marked other than "r 12th grade (0-12) Service Station Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Williams Peter J. Jackson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46236 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra 6823 Bitter Sweet Lane, Indianapolis, Jahwral Jacques-Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 2/18/10 Baltimore, Md On-Site 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility Masch Wabash Ave, 21. Signature of Funeral Service License Baltimore, Md 21215 Approximate Interval Between Onset and Death ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each lipe. Part 1. Enter the disease, or complications shock, or heart failure. List only one Immediate Cause (Final holangio Carcinoma Lucun Physician disease or condition resulting in death) /Medical Due to (or as a couse uence of): Examiner Sequentially list conditions, any locality immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) ned by the a 9 Unknown 9 Unknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≨</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed. Yes 2 No certificate I 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No

law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, Physician:

with

72 hours after death

Baltimore, Maryland 21215-0036

funeral director, To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral After

State

Registrar

Medical

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

investigation

6 Could not be determined

Print) 2 16 10
Print) Levard, Baltimore, Maryland 212-18 31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

FEB 19 2010

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month Day Mae Jackson Notra 02 3 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Manor Care Nursing Home Date of Bill... (Month, Day, Ye 13 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Months Hours 1 □ M 2X□ F 213-34-0763 Director 71 38 MD Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State with the Maryland event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 23a Funeral 439 Oxford Ct. 21201 U.S.A. items permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc Completed by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) llth grade College (1-4 or 5+) Laundry Room Assistant Baltimore Housing na Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Thomas Wright Hortense Floyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 439 Oxford Street, Baltimore, Md 21201 Denise Washington-Daughter injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion 2/24/10 Baltimore, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Signature of Funeral Service Licensee any Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Athens clerotic Immediate Cause (Final Priysician/ ID disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury True to for as a consequence of and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a lor use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has funeral director, page 2: autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🔲 No Investigation Accident 24 hours after deatle Funeral Director, 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and title of certifier 10 migr-0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

UD 6

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR 9900 2/19/10 TT
State of Maryland Department of Health and Mental Hygiene 20 10 04505 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2010° Richard Harvey Jackson 11:33 AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Baltimore Baltimore 0+ . Social Security Numbe Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X**X M 2 □ F July 24,193 Hours Pennsylvania 204-22-1769 78 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tiere 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Howard Columbia 0e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5076 Drywell Court 21045 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Narried 1XX Yes Completed by 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes. Give 3 Widowed 4 Divorced Army White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) attent leven as Salesman Telephone Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William H. Jackson Margretta Dalton 19a. Informant's Name/Relationship (Type, Print)
Betty Jackson (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, Maryland 21045 5076 Drywell Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2xx Cremation 3 Removal from State 2-16-2010 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 art 1. Ent. the lisea e, or o mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or have failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ulmonar Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last attending physician Physician/Medical Box 68760 as the I IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 2 1 No ည I ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funeral place in by the funeral completed filled fill 1 Natural 5 Pending Division 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Certifying Nurse Practioner: To the best of my knowledge death occurred at the time date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 2010 no completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore, Baltimore, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Februar 2010 Johnson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center NN 5. Social Security Number If Under 1 Year 6 Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 E F Months Hours March 13 1913 96 Yrs TNDirector 415-50-8079 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a, State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21144 USA 8094 Telegraph Road 1 and 2 should be filed within 72 hours after death w of Health and Mental Hygiene.
item 27 is marked other than "natural", or items: other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 9 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Manufacturing Line Assembly Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Mary Adams Gordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 131 Lake Shore Drive, Pasadena, MD 21122 L. Joyce Menzel (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Feb. Date permit. Page 1
Department of
Important: If it
any injury or o 23 cemetery, crematory or other place)
Meadowridge Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 of Funer | Servi 21. Signatur 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. 23a. Part 1. Enter the disease, or co shock, or heart fature. List only Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a co sequence of) **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury Duit to for all a consequence of and that initiated events resulting in death) Last Due to (or as a consequence of). physician are the burial-t Physician/Medical the attending phone of the transfer of the tra IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown cate has been signed by to page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. 2 DNo 1 Tes 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has I autopsy performed? Yes 2 No 2 No 1 🗌 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 12 No ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending 1 Yes 2 No M within 24 hours after death

To the Funeral Director: completed filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1-2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death - Menth Physician/ Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6. Sex 1 M 2 □ F If Under 24 Hrs 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Nonth, Day, Ye Min Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married by 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. Specify: 3 ☐ Widowed 4 ☑ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) oron 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Si nature Funeral Service Licerses 22. Name and Address of Fari 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cante Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 _ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 Pregnant a Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 🗌 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has h autopsy page 2 performe Yes 2 No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, Be Hospital: 2 🕅 No 은 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 19 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signat 20/0

State Registrar 6701

and address of person who completed cause of death (Item 23a) (Type, Print)

CHANGE

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician ∆**6:30 A^M February 06 2010 Millard Jenkins /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner timore Par I If Under 24 Hrs. tane <u>Baltimore</u> 9. Birthplace (State or Foreign Country) UNK 5. Social Security Numberink Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Min 1 □ M 2 🖾 F Yrs. April 1Ó, 1943 66 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10h County 10c, City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Evantary or unstitute sufficed at 1X Yes 2 □ No MD Baltimore Baltimore Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21229 USA 22 S. Athol Ave. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 1 Never Married 2 Married Specify: black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Un.
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) unk 18. Mother's Name (First, Middle, Maiden Surname)unk 17. Father's Name (First, Middle, Last) unk Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a 900 S. Caton Avenue; Baltimore, Maryland 21229 St. Agnes Hospital other 1 Department of Heal Important: If item 2 any injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ☑ Other (Specify) in State 21. Signatur of Funeral Savice Lic Walls State and Address of Facility oard; 655 W. Baltimore Street Director 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate ruse (Final disease or or or didtion resulting in death)

a. Provide the mode of dying, such as cardiac or respiratory arrest, since the mode of dying are cardiac or respiratory arres Baltimore, Maryland 21201 Approximate Interval Between Onset and Death **Physician** veeks /Medical Due to (or as a consequence of): Examiner Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner rneumonia physician and s the burial-trant Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending p Jenkins, Millard IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) the a 9 I Inknown been signed by should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 tructive Pulmonary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an certificate has page 2 autopsy 25. Was case refarred to medical examiner? 2 **D** No Failur 1 ☐ Yes funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A investigation 2 Accident the ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 06,2010 P24063

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Caton Arenue Baltimore, Maryland 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shannarose Nigrelli 900 Catom

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Kopet February Ann 11:13 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Lutherville 1220 Charmuth Rd. Baltimore 5. Social Security Number g. Birthplace (State or Foreign Country) 1908 Czechoslavakia If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Yea 1 □ M 2 🕅 F Hours 101 214-54-6423 Director Sept. Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Lutherville Marvland Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21.093 1220 Charmuth Rd. United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 X Widowed 4 □ Divorced white Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) 12 College (1-4 or 5+) homemaker own home Be 18. Mother's Name *(First, Middle, Maiden Surname)* Mary Sargeant 17. Father's Name (First, Middle, Last) George Knezo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 1220 Charmuth Rd. Lutherville, MD 21093 Joan Kern/daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem GardFeb. 23,2010 Timonium, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee John O. Mitchell IV, Funeral Services of Dulaney Valley, 200 E. Padonia Rd. Timonium, MD 21093 P.A. It 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ Advirw ced disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and -trans resulting in death) Last Due to (or as a consequence of): ng physician ar as the burial-to Physician/Medical requires that the death certificate be Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) ____ Dav Pregnant at time of death 1 Yes 2 V detached 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Division of Vital Records, HYPERTENSION 1 ☐ Yes 2 🖼 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available 24a Was an the Hospital or Attending Physician: The law After this certificate has autopsy pertorme prior to completion of cause of 1 Yes 2 No 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 1 Tes 2 DNO ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending injury work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deatl To the Funeral Director: the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) nelhu 120052292. 12/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINDITA - JAMUS m1) d/093 1447 YORK ROAD LUTHER VILLE

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

1 9

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb. 1 7 ay Joan T. Kroll 2010 10:30aM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Brighton Gardens Towson 8. Date of Birth
OCT . 15, 1938 Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday Funeral Months Days 219-26-4794 1 - M 2 X Hours Country) 71 MD Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Baltimore 1 Yes 2 No Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Charles Street 6451 N. 21212 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Balto. CountySchool 8th Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Joseph Messenger Sr. Thelma Helldorfer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Stephen Kroll /son 43652 Riverpoint Drive Leesburg VA 20176 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of remetery, crematory or orner piace)
Holly Hill Cemetery 2/20/10 1 Burial 2 Cremation 3 Removal from State Baltimore MD 4 Donation 5 Other (Specify) 21. Signature Fune al Servi 22. Name and Address of Facility Balto. MD sex 21221 300 MAce Ave. Connelly Funeral of Essex Home tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, of comp Approximate shock, or heart failure. List only one Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal 3... 4 ☐ Pregnant at time of death Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 🗆 Yes 2 🗔 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **X**No Other: ျှ 1 Inpatient 2 I ER/Outpatient 3 ₩Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 1 ☐ Yes 2 ☐ No **⊠**Natural derth. Accident Investigation within 24 hours arer death

To the Funeral Director

completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Medical

29a. Certifier (Check

29b. Signaty

only one)

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month February 10 ____ Day 111 YUAM **Physician** Koontz Marilyn Joan /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BOUTMONE HOJPITAL RALTIMORG いろうない Aurves Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months Hours 1 □ M 💥 □ F 79 Director 213-28-8305 24 30 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, if a Medical Exp. in activities of any injury or other traumatic event, if a Medical Exp. in activities of any once. 1 ☐ Yes 2 X No Catonsville Director MD Baltimore 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 2 should be filed within 72 hours after death with to and Mental Hygiene.

is marked other than "natural", or items 23a or? U.S.A. 21228 1 Rumford Drive Unit 101 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □ No White Specify. Specify: 2 3 ☐ Widowed 4 🔀 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Social Security Adm. Clerk 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena Koerber Ferdinana Weber 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 60 West McCabe Street, Selbyville, DE 19975 David Koontz-Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/18/2010 Baltimore, Md On-Site 4. □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
March F/H Wes
4300 Wabash 21. Senat ve of Funeral Service Licerisee št Ave, Baltimsore, Md 21215 23a. Patt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Faf VE multipie Drgan ī Physician SEPSIS week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions The to for an a consequence of Examiner cause. Enter Underlying Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 ☐ Unknown 1 Tyes this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 HO of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier mD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) cator Avenue DID SAFTI 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Year **Physician** Paul Howard Keenan, Sr. Februar 17,2010 11 /Medical $oldsymbol{\mathcal{O}}_{ ext{4c.}}$ County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Koseda tranklin Square Pital Center timore 291 9. Birthplace (State or Foreign Country) Maryland If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 9,1923 Social Security Number Age (In yrs. last birthday. Sex 14 M 2 □ F **Funeral** Months Days Hours Min 218-14-0859 86 May Director Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Evaminer must be notified at 1 □ Yes 2X No Director Md. Balto. Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 307 Tidewater Lane 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No 12Xes, Give Year or Dates: 1943-1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc filed within 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Head Buyer BG&E Customer Ser. Div. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f Howard A. Keenan Hilda Collier ٩ other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 of Health a Paul H. Keenan, Jr. Son 8922 Parlo Road Nottingham, Md. 21236 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date ò 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or Most Holy Redeemer 2-20-2010 Balto.Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** alveolar Hemorrhage + ibrosi disease or condition resulting in death) -ung /Medical Due to as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician ned for use as the burial use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 □Yes 2 □No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 √Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boltimore MD. 21237 Frankl Quare State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per dec 900 2-19-10 who Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEBRUARY 2010 DORIS MARIE KAINE 9:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford House of Jubilee Assisted Living Fallston Birthplace (State or Foreign Country)
 New Jersey If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, 1 🗆 M 2 🕮 F Director 143-14-0166 86 1923 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1X Yes 2 No Bel Air Maryland Harford 10f. Zip Code 10g, Citizen of What Country? Funeral 120 W. Broadway Unit A 21014 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: 3 ☑ Widowed 4 ☐ Divorced White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medi-al I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry (unk) Schroll Mabel (unk) (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 717 Grady Lane, Bel Air, Maryland 21014 Joseph Kaine / Son 20a. Method of Disposition

Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 2-19-10 Baltimore, MD 2. Name and Address of Facility McComas Funeral Home, 1317 Cokesbury Road, 21. Signature of Faneral Service Licenses Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirators shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ relovos disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate Examine Due to or as a consquence of cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No
9 Unknown Month Day 5 Other (specify) Year Pregnant at time of death ate has been signed by the page 2 should be detached P.O. Part II. Oth<mark>er significant conditions</mark> contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted Living Other: မ 2 X No 4 Nursing Home 3 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital Medical 29a. Certifier Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and the 29c. License number 29d. Date signed (Month, Day, Year) 39 Name and address of person who completed cause of death (Item 23a) (Type, Print) DIMONSON 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

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			For State Registrar		State of M	arylan			nt of F te of L		ind M	ental Hy	/giene Reg. No			
	Physicia Medic		1. Decedent's Name (First, No. Stephen Pau										eath ry Î	201	3. tu	ne of Death 4
0	Examin		4a. Facility Name (if not instit	-			-		y, Town, or moniu	Location of	Death		40	. County of D Baltin		
4.5	Funeral Director		5. Social Security Number 064-34-4213	6. Sex		e (In yrs. la	ast birthday) Yrs.	If Unc	er 1 Year Days	If Under 2 Hours		8. Date of Bi (Month, D PTIL I	rth ax Year 1	Birthplace (St Country) CW Yor	ate or Foreign	
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	with the N s 23a or 28 ust be not	Funeral Director	10e. Street and Number 502 Willow	Ave.					ip Code 157				10g. C	tizen of What	Country?	
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Fun	11. Marital Status 1 🕱 Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo	Married	12. Was Decedent E Armed Forces? 1 🛣 Yes 2 If Yes, Give Year or Dates.	No 19	59-			ispanic Orlgi n, Mexican, Specify:	in? (Speci Puerto R	ify Yes or No ican, etc.)	-		merican India /hite, etc. hite	n,
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Baltimore,	Page 1 a ment of H tant: If ite ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Ot				lace of Disp emetery, cre			e)	Da	ate	20c. L	ocation - City	or Town, Sta	te
Balt	permit Depart Import any inj once.		21. Signature Funeral Sec	License	My hive	otor				ony Bo Mary			W. B	altimo	re Str	eet
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/ital	sician: The certificate lirector, pag	To Be	25. Was case referred to me- examiner? 1 Yes 2 X No	_	lospital:		ER/Outpatie	nt 2 🗆	Oth	ace of Death er:			id	OAbou (C	nooifel UO	PDTCF
on of \	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	Certificate: T	2 Accident Ir	ending vestigation	28a. Date of inju (Month, Da	ry	28b. Time of injury		28c. Injun	4 Nursing Home 5 Residence 6 Other (Specify) HOS				JI TOE		
Divisi	ial or Attendi s after death. al Director: A ed in by the fu			ould not be etermined	28e. Place of Injubul	ry - At ho	me, farm, st	reet, facto	ry, office		2	8f. Location City or To			Rural Route I	Number,
	To the Hospital of within 24 hours at To the Funeral D completed filled it	Medical	(Check 2 DMed	ical Examin	cian: To the best of er: On the basis of e Practioner: To the	xamination	and/or inve	stigation, i	n my opinio	on, death occ	curred at t	he time, date	and place	e, and due to t	the cause(s) ar	nd manner stated.
	With With Com		29b. Signature and title of ce	ertifier	12. Dr	KIT	9	2	oc. License	number 7624	G		29d. Da		anth, Day, Yea	,
			30. Name and address of pe		7				/						WU/U	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death **Physician** Year 1018 AM 2010 rebruar /Medical Facility Name (If not institution, give 4b. City, Town, or Location of Death Examiner 4c. County of Death andall Stown WD If Under 24 Hrs. 8. Date of Birth Hours Min. May 20, 1944 Social Security Number 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) Mary Land Months Days 1**X** M 2□ F 216-42-6392 65 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Midcal Erannica. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Baltimore Owings Mills 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 S. Tollgate Rd 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1062 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1≦Yes 2 No 1962− If Yes, Give Year or Dates: 1969 Black, White, etc. 1 ☐ Never Married 2 Married 1 ∐Yes 2X∑No þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) trucker transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Kapper Stella Cohen မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Kapper/wife 15 S. Tollgate Rd; Owings Mills, Maryland 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Donation 5 Tother (Specify) 21. Signature of Ronard Section 21. State Addreson Board; 655 W. Baltimore Street Дe /Director Baltimore, Maryland 21201 23a. Part | Enter the dis "se, "f complications that caused the death shoc or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Verse (Final disease or condition resulting in death) Physician hours /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Division of Vital Yes Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 □ No Medical Certification: To 2 ER/Outpatient 3 □ DOA 1 🔲 Inpatient this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation dealh. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attended within 24 hours at er death To the Funeral Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certific

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

FEB 19 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Long Month Mark Gary FEBRI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON JOSEPH MEDICA 8. Date of Birth (Month, Day, Year) March 14,1956 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 X M 2 □ F 215-68-4399 Mary land Director 53 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturo" any injury or other traumatic acce. 10c. City, Town or Location 10d. Inside City Limits 10a. State **Funeral Director** 1 🗆 Yes 🔀 No Parkville Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 2293 Lowell Ridge Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 212 No Completed by 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Law Offices Clerk Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Charlotte J. Kellogg မ Leroy R. Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Father) Leroy R. Long Joppa, Maryland 669 Trimble Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem 2/19/2010 Middle River, MD Gdns. 4 Donation 5 Other (Specify 21. Signature of Funeral Service Lice 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Milia 7922 Wise Ave. <u>Dundalk, Maryland</u> 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) GASTROINTESTINAL Medical Examiner PHAGEAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner for as a consequence ou FALLURE that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
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To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes Other: 2 No 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital within 24 hours a To the Funeral C 🜠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) we 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

istrar's Signature

115

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Rose Marie Lengrand 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Examiner Ros Square 8. Date of Birth (Month, Day, Year) 6-22-1963 5. Social Security Number (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Min. Hours 1 □ M 2 □ X = Months Davs 46 Director 218-90-3748 MD Usual Residence of Decedent 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "horizel Eventible" in ast be muffled at once. Director 1. PYes 2 □ No MD Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 Northship Road 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Bace - American Indian 1 ∐Yes 2 K If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 □Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ၉ Donald R. Grygewski Catherine Wisniewski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jr.-Northship Road, Dundalk, MD 21222 Victor Lengrand 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 2-22-10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licensee 2134 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical the as attending plant for use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) P.O. 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performe certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 ∐Yes 2 X No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∏Yes 2 KiNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending ↑ Natural 2 ☐ Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0105 D36663

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		For	State of M	aryland	-		lealth and	Mental H	ygiene	0010		
	_	State Registrar			Cer	tificate of	Death	1	Reg. No.	<u> 2010</u>	04518	
Physicia	ın	1. Decedent's Name (First, Middle, L.						2. Date of I	Day		3. Time of Death	
/Medic	al .	ELIZABETH M. LAH				4h City Town o	or Location of Deat	FEB.	17	2010 County of Death	10:28AM ^M	
Examin	er	4a. Facility Name (If not institution, gi Oak Crest Care C		,		Parkvi		"		altimor		
Funeral				ge (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of E	Birth	g. Birth	nplace (State or Foreign	
Director		220-07-1378	1□M XX F	89	Yrs.	Months Days	Hours Min.	May 16	, 1920 , 1920) Oĥ	intry)	
pu ,		Usual Residence of Decedent		100 City	Town or Loc	ation					10d. Inside City Limits	
aryla shov	'n	10a. State 10b. County Maryland Balti	momo	Toc. City,			County~	Darkvi	110		1 □Yes XXNo	
the M	Director	Maryland Balti		1		10f. Zip Code	Courty	I GIKVI		izen of What Co	untry?	
with Ba or	٥	8832 Walther Blv	d				21234		Ů			
death	Funeral	11. Marital Status	12, Was Decedent	Ever in U.S.	. 13. V	Vas Decedent of I	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or		14. Race - Amer		
should be filed within 72 hours after death with the Maryland tand Mental Hygiene. I will Mental Hygiene s marked other than "natural", or Items 23a or 28a-f show umatic event, If a Modical Eventral rate routified at	Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces' 1 ☐ Yes ※ If Yes, Give			Yes, specify Cub		to Rican, etc.)		Black, White		
ural",	d by	Widowed 4 Divorced	Year or Dates:						405 (6			
"nat	lete	15. Decedent's E (Specify only highest g	rade completed)		16a. Deced (Give . life. L	lent's Usual Occu kind of work done OO NOT use retire	pation during most of wo d)	rking	Gre	nd of Business/I ater Ba	ltimore	
withii jiene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)			ptroller		Med	lical Ce	nter	
al Hyg other	Be C	17. Father's Name (First, Middle, Las	st)				18. Mother's Na			Surname)		
uld be Menta srked	일	Harvey Reed, Sr.					Maud	e Simme	115			
2 sho n and is ma		19a. Informant's Name/Relationship				-	t and Number or R					
l and Health		Barbara Stone (D	augnter)	20h Bla			lestwood	Date		ocation - City or		
nt of h		20a. Method of Disposition 1X☐ Burial 2 ☐ Cremation 3		9		sition (Name of natory or other pla						
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Inpertantent of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinating must be notified at once.		4 □ Donation 5 □ Other (Spec		Gard		f Faith		-2010	рати	imore,	Mu.	
Depril De		Months of the)() max			7401 Bela	Foneral H air Rd. E	nome Baltimo:	re, Mo	d. 21236	6	
		23a. Part 1. Enter the disease, or conshock, or heart failure. List only			Do not ent	er the mode of dy	ing, such as cardia	c or respirator	arrest,		Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	Fnc		.ce	Demen	tic				Onset and Death	
/Medical		resulting In death)	a	s a conseque								
Examiner	_	Sequentially list conditions,	b									
ted 1sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	s a conseque	ence ot):							
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leath certifica attending ph I for use as th	an/N	IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy								23d. Date of del		
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Med	in the past 12 months? 1								Month Day Year		
hat the		Part II. Other significant conditions	contributing to death	but not resul	Iting in the u	nderlying cause gi	ven in Part I.	23e. Di	23e. Did tobacco use contribute to the cause of death?			
uires uires in sign	d by							11	∐Yes 2	ØNo 3□ Pi	3 Probably 4 Unknown	
w req	lete	-						24a. W	as an	24b. Were au	utopsy findings available	
he law te has age 2 :	Completed							, pe	rformed?/	death?	completion of cause of	
an: Triffica tor, p	Be C	25. Was case referred to medical					26. Place of De		s 2. ZnNo lyone)	I ILITES	2,2110	
nyslc ais ce direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpa	tient 2 🗆 E	ER/Outpatier	nt 3 □ DOA Ot	her: 4 Nursing	Home 5□R	esidence	6 □Other (Spe	cify)	
Attending Physician: r death. ector: After this certific by the funeral director,	on:	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of In (Month, D		28b. Time of Injury	Wo		28d. Descril	e how inju	ry occurred		
tendi leath. tor: A	cati	2 Accident investigati 3 Suicide 6 Could not		nium. At han	no form str]Yes 2□No	20f Leastin	Chroat a	and Alumbaras Di	ural Route Number,	
or At after of Direc	Certification:	4 ☐ Homicide determine	building,	etc. (Specify	ne, iarm, str	eet, factory, office		City or	Town, State	e)	urar noute Number,	
Hospital 24 hours a Funeral l		29a. Certifier 1 CertifyIng	Physician; To the bes	st of my knov	vledge, deat	h occurred at the	time, date and place	ce, and due to	the cause(s	s) and manner a	s stated.	
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical	(Check only 2☐ Medical Ex	aminer: On the basis and manner	of examinati stated.	ion and/or in	vestigation, in my	opinion, death occ	curred at the tir	ne, date an	d place, and due	to the cause(s)	
To the within 2 To the comple	ž	29b. Signature and title of certifier				29c. Licer	ise number		29d. Da	ate signed (Mont	h, Day, Year)	
		la mi	one	\supset		D58	646		Fe	bruare	1 17 2010	
6		30. Name and address of person wh	o completed cause of	death (Item) 0	1		1. ~ -		
Sta	to	Anna Monics 31. Date filed (Month, Ray, Year)	\$ 8 00 U	trar's Signati	urg	buleuc,	d Pa	11:0/2	e	MH 2	1234	
Registr		31. Date filed (Month, Pay, Year)	Beneva	A. 14	fare							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 per INF G901 3/01/2010 Jh
State of Maryland / Department of Health and Mental Hygiene

1- State Amend Item 24a per verb., g900, 02/19/2010dhb
Registrar

Reg. No. 2 | | | 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY Bay 5 :25 M Physician/ 2010 Judith Ann Loveday Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death **Examiner** Washington Washington County Hospital Hagerstown Social Security Number 264-34-7064 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days March 19, 1944 Hours Min. 1 □ M 2 🖾 F Pennsylvania 64-34-7064 65 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director MD Washington Hagerstown 1 Tes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral 21740 17521 Lexington Ave. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry un 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) 0 receptionist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert A. Knox Sylvia Loraine Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11226 Marbern Rd; Hagerstown, Maryland 21740 Jeffrey Loveday/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signalure of Funeral So ice Licensee 22 Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Raltimore Maryland 21201 Part V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Medical **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Tonknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be ☐ Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 26 . N. D 218110 30. Name and address of person who completed cause of death (item 23a) (Type, Print) MD 251 East antictam St. Hageista Kalka 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month February trieda Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) an. 12. 1918 217-03-4529 1 M 2 XF 92 Director Usual Residence of Decedent or 28a-f show 10a. State 10h County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director Silver Spring Maryland! Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20903 United States 8500 New Hampshire Ave., #341 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. White "natural", or 1 Never Married 2 Married 1 Yes 2 No Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Jewelry Salesperson Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fili Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic eve Clara Shane Max Caplan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8500 New Hampshire Ave., #341, Silver Spring, MD Inez Lebow, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 208. Lacation - City or Town State 02/22/10 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Isaac Adath Israel Congregation Cemetery 21. Signature of Filmeral S Torchinsky Hebrew Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Colitis Ischemic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause in the Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a consequence of attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 9 Unknown is been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by history of 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? Hyper lipidemia 24a Was an autopsy performed? Yes 2 X No has **Division of Vital** Be (25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Natural 2 Accident 3 Suicide 4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Year

2010

3: 25 PM

Birthplace (State or Foreign Country)
 Mary and

10d. Inside City Limits

20012
Approximate
Interval Between Onset and Death

2000

1 Yes 2 No

,17,2010

1 ☐ Yes 2 XNo

Hospital or Attending Physician; To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun

State

Medical

29a. Certifier

29b. Signature and title of certifier

Sean S Saedi MD

Sean S Saedi: 11120 New Hampshire Ave, #305 Silver Spring, MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D-60359

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ELSA L. LEIMBACH repriary /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examine N/A nerai If Under 1 Year | If Under 24 Hrs., Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Year Months Days Min 1 □ M 2√2 F 91 Yrs. 215-03-4075 Director FEB. 15,1919 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the inedical Examination confidence. 1 XYes 2 ☐ No Director BALTIMORE N/A MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21214 3415 ROSELAWN AVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ∐Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married WHITE 1 □Yes 2 No 21215-0036 Specify. \$ 3 Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TNSURANCE CLERK Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOUISE KOSSMAN ROY C. MACAULEY ဥ 19a. Informant's Name/Relationship (Type. Print)
DAVID LEIMBACH-SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4231 SLATER AVE BALTIMORE, MD 21236 permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau once. 3altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 2/19/10 BALTIMORE, MD GARDENS OF FAITH 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, 21. Signature of Euneral Service Licenses BALTIMORE, MD 21206 6415 BELAIR RD ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of) Examiner taneous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) burial-Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p nse : IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 3 Probably 4 ☑ Unknown 2 ☐ No 1 Yes Completed page 2 should .24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 12 No certificate 2 No 1 ☐Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral c 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural n 24 hours after death.

In Funeral Director: Af alletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier R. DEULOTA, MD Name and address of person who completed cause of death (Item 23a) (Type, Print) 20) · 70 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

			For	State	of Ma	aryland	-	artment of F		nd Ment	tal Hygie	ne		
			1 - State Registrar				Ce	rtificate of	Death		Reg.	No.	010	01-50
Physi /Me			1. Decedent's Name (First, Middle, BETTY SU		Ξ					l N	ate of Death Month b 1	Day 1	2010	3. Time of Death 2 2
Exan			4a. Facility Name (If not institution,	-				4b. City, Town, or	Location of	Death		4c. Coun	nty of Death	
, *			Forestville Health & Rehab. Center Forestville Prince											
Funer: Directo			579-78-6669	6. Sex 1 □ M 2 🖾 F		5 7	ast birthday, Yrs.	Months Days	If Under 24 Hours	Min. (A	ate of Birth Month, Day, Ye 16, 1		9. Birthpla Countr	ace (State or Foreign ry) NC
and	,		Usual Residence of Decedent 10a. State 10b. County			10c. City	, Town or Lo	ocation					100	d. Inside City Limits
Mary -f sho		5	MD Prince	Georges	,	For	estvi	110						1 ∐Yes 2XX No
r 28a		Director	10e. Street and Number	deorges	,	ror	ESLVI.	10f. Zip Code			10g.	Citizen of	f What Countr	y?
th with		ם מ	7420 Marlboro P:	ike				2074	7			USA	A	
r deal		rulleral	11. Marital Status	12. Was De	ecedent E Forces?	er in U.S	6. 13.	Was Decedent of H	ispanic Origi	in? (Specify Y	(es or No-	14. Ra	ace - America	
ine, infall yiellu Z I Z I D-0.00 stand 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. The axis marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exemits or must be notified at	j	2	1 ☑ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 □Ye If Ye <i>s</i> ,	1 Yes 2 ⊠ No If Yes, Give Year or Dates:			1 □Yes 2KNo	Specify:	T del to Tilodii	, 60.,	etc.) Black, White, etc. Specify: Black		
72 hc 72 hc natur		מופר	15. Decedent's (Specify only highest	Education	d)		16a. Dece	edent's Usual Occup	ation	of working	16b	. Kind of I	Business/Indu	stry
within sne.		completed	Elementary/Secondary (0-12)		(1-4or 5	+)		kind of work done of DO NOT use retired		or working				
filed v Hygid ther			12th 17. Father's Name (First, Middle, Li	ast)			Offic	cer Cleane		's Name <i>(Fir</i> s	t, Middle, Maid	rivat den Surna		
id be ental ked o	á	2	William Perry 1							.11e Ho		ion ouma	1110)	
shoul Mind Mind Mind Mind Mind Mind Mind Mind	F		19a. Informant's Name/Relationshi				19b. Maili	ng Address (Street a				tv or Towi	n. State. Zip C	Code)
und 2 aulth a 27 is	- [1]	1	_Pamela Terry -	Sister				Elmhurst						•
of He fittern			20a. Method of Disposition		_	20b. Pl		osition (Name of matory or other place		Date			- City or Tow	
Page ment ant: It			1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		m State			itan Crem	i	2-20-2	2010 A	1exa	ndria,	VA.
permit. Pages 1 and 2 si Department of Health an Important: If item 27 is uny	once.		21. Signature of Juneral Service Li	censee A	11)	mil	1,73	2. Name and Address Marshall s 4308 Suit	ss of Facility Fune	ral Ho	me of I	Mary1	land	
		+	23a. Part 1. Enter the disease, or c	omplications tha	t caused	the death.						<u>, MD.</u>	-	Approximate
Physicia			Immediate Cause (Final	nly one cause or	n each lin	e.							I	nterval Between Onset and Death
/Medica	al l		disease or condition resulting in death)			consequ		nosarcoma	with .	metast	asis			
HEE	į	2	Sequentially list conditions,	b. Due t	Carasa	s conseque	ente off							
cuted nd ransit	E Aminor		cause. Enter Underlying Cause (Disease or injury that initiated events	c.										
icate be executed physician and the burial-transit	<u> </u>		resulting in death) Last	Due t	o (or as a	consequ	ence of):							
	1		110.00	d										
The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Dhyeician/Medical) Signature	in the sect to wearth and 11 Live pirth 21 Fetal death 31 Ectopic pregnancy								ate of delivery fonth D	y Day Year		
that ned b			Part II. Other significant condition	s contributing to	death bu	t not resul	ting in the u	nderlying cause give	n in Part I.	2	3e. Did tobaco	o use cor	ntribute to the	cause of death?
w requires to be a signer should be a	yd bo										1 ☐ Yes	2 No	3 ☐ Probal	bly 4☑ Unknown
The law rate has be page 2 sh	Completed									_	4a. Was an autopsy performed □Yes 2★	?	were autops prior to comp death? 1 🗆 Yes 2	sy findings available pletion of cause of
Physician: The rules certificate ral director, pag	A O	,	25. Was case referred to medical examiner?						26. Place o	of Death (Che			12100 2	
hysi this c	ß	2	1 ☐ Yes 2 ဩtNo				<u></u>	nt 3 □ DOA Othe	4 🔯 Nurs	sing Home 5	5 ☐ Residence	6 🗆 O	ther (Specify)	
. 50 0 0	ertification.		27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investiga	(Mc	te of Injur onth, Day		28b. Time o Injury	Work	rat ? ⁄es 2 ∐ No		escribe how in	njury occu	ırred	
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Certific		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be ed 28e. Plac buil	ce of Injui	ry - At hon (Specify)	ne, farm, str	eet, factory, office		28f. Lo	ocation <i>(Street</i> lity or Town, St	and Num	nber or Flural f	Route Number,
n 24 hou Re Funer	ledical		29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	caminer: On the	he best o basis of anner stat	examinati	ledge, deat on and/or in	h occurred at the tin vestigation, in my o	ne, date and pinion, death	place, and do occurred at	ue to the caus the time, date	e(s) and r and place	manner as sta e, and due to t	ted. he cause(s)
Vithi To th	Me		29b. Signature and the of certifier				-	29c. License	number		29d.	Date sign	ned (Month, Da	ay, Year)
			• 11/WW					D51	520		2	/15/2	2010	
			30. Name and address of person wi Bahram Pishdad,	MD 1	328	South	ern A	ve. SE W	lashina	oton '	DC 2003	32		
	tate		31. Date filed (Month, Day, Year)	32.	Pegistra	r's Signatu	ire	bouted !	4011411	B = 0119	2002	,		
Regis	trar		FEB 19	2010	ine.	a ,	D. 19	W. Carrie						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Richard Dennis Murphy hrvan 20/0 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death dale (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) cial Security Numbe Date of Birth (Month, Day, Yeer) Days 1 X M 2 □ F Months Hours 219-90-6630 67 09/06/1941 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD Baltimore White Marsh 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5600 Carrington Drive U.S.A. 21162 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 1 ∐Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Murphy Kidwell Doris Mae 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Murphy-Adams / Sister 7353 Brangels Road, Marriottsville, MD 21104 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Anatany Gifts Registry 02/17/2010 Hanover, Maryland 21. Signature of Funeral Service Licen, ee 22. Name end Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)

Physician Medical Examiner

permit. Pages 1
Department of H
Important: If ite
any Injury or ot

Pages 1 and 2 should be filed within 72 hann of Health and Mental Hygiene.

Baltimore,

Physician

/Medical

Examiner

Funeral

Director

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Director

Funeral

Completed by

Be

2

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

I Director: /

the Funeral Dire

use as the burial-trans and the attending physician ned for use as the burial detached cate has been signed by page 2 should be detach certificate

After this

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	d								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									
Pert II. Other significant conditions	contributing to death but not resulting in t	the underlying caus	e given in Part I.			o the cause of death? robably 4 ☐ Unknown			
				24a. Was an autopsy performed? 1 X Yes 2 □ No	prior to deatb?	utopsy findings available completion of cause of 2 No			
25. Was case referred to medical			26. Place of Death (Check only one)					
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outp	5 ☐ Residence	6 ☐ Other (Spe	cify)					
07 Manager of Decade	00 D (()) 000 T								

25 27. Manner of Death

5 Pending investigation

28a. Date of Injury (Month, Day, Year) 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

1 □Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural 2 Accident

3 ☐ Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Continue of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. and manner stated. 29c. License number

29b. Signature and title of certifier

1 9 2010

29d. Date signed (Month, Day, Year) 02.08.10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Malinin

31. Date filed (Month, Dey, Year)

9000 Fran

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 2,25 per me,g900,02/18/2010dhb,30

Reg. No. Reg. No. 2. Date of Death 01/15/2010 1. Decedent's Name (First, Middle, Last) Mc Knight Month **Physician** Hnge/a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Secours Hespital If Under 1 Year | If Under 24 Hrs. | Hours | Min. N/A Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1 M 2 D Director 213-88-9871 Jul 7, 1972 Maryland Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1679 Vincent Court Funeral 21217 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give **X** Year or Dates: or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No þ Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) **Baltimore City** Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Charles M. McNeill Irish McNeill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irish McNeill 2204 West Fayette Street Baltimore, Maryland 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/22/10 Mt. Zion Cemetery
22. Name and Address of Facility Lansdowne, Maryland 21. Signature of Funeral Service Licenses Estep Brothers Funeral Service, P. A.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode or dying, such as cardiac or respiratory arrest, limited that Cause (First) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stage End **Physician** /Medical Due to (or as a consequence of): **Examiner** Spiration Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER requires that the death certificate be executed and Due to (or as a consequence of) nding physician use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d Date of delivery 3 Ectopic pregnancy Month Dav Vear 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Hinknown 9 Onknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Huperten sion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Johnknown 24b. Were autopsy findings available prior to completion of cause of death? Asthmo 24a. Was an autopsy perform 25. Was case referred to medical examiner? Mellitu 1 □ Yes 1 ☐ Yes 2 ☐ No 2 1 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Dax63565 &Benn-Thompson, M.D. Jan. 15,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)
FEB 1 9 2010

an Registrar's Signature

Sherron Benn-Thompson, Bon Secours Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g901 3-15-10 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Margaret Virginia Med1in 5:34 PM 11,2010 /Medical February 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Harford Bel Air Upper Chesapeake Health 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2√ F Director Nov. 16,1918 North Carolina 414-07-7506 Usual Residence of Decedent 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Evaminer must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 720 Linwood Ave. 21014 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 □Yes XXXNo Specify: ģ Specify: 3 ₩idowed 4 Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 10 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H Margaret M. Febuary Frank R. Potter ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Poist (Daughter) Health 3136 Main Ave. 21219 Edgemere, Maryland other t Important; If item any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō 1 🗵 Burial 2 ☐ Cremation 3 ☐ Removal from State $2\sqrt{\frac{17}{17}}/2010$ 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Oak Lawn Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a, Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 12C da disease or condition resulting in death) 10ule /Medical Due to (or as a consequence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 3 ☐ Probably 4 ☐ Unknown 2 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 21 2 No 1 □ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 \(\text{Nursing Home} \) 1 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation 1 Tyes 2 No filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

State Registrar

(Check only one)

29b. Signature and title of certifier

and address of person who completed cause of death (Item 23a) (Type, Print)

Maryland 21215-0036

altimo

29c. License number

crá

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D2010 Feb. Gregory Marshall Metrinko 17 8:45 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days July 18 1 **∑** M 2 □ F Hours ^(ear)1943 **Director** Yrs Pennsylvania 66 178-34-4660 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Director 10d. Inside City Limits 1 ☐ Yes 2 No Pa. York New Freedom 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Dominion Drive 17349 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: "natural", 3 Divorced 4 Divorced Completed Specify: White injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ould be filed within 72 and Mental Hygiene. Anne Arundel County Elementary/Seconday (0-12) College (1-4 or 5+) 5+ School Administrator **Board of Education** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Harry Metrinko Gawryluk Alice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Florence Metrinko/Wife Dominion Dr. New Freedom, Pennsylvania 17349 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 2/23/10 Towson, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or c. or lications that cause d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between a set and Death Immediate Cause (Final Physician/) Medical resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed death? certificate 1 ☐ Yes 2 ☐ No ☐ Yes Be (Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 000 1 🗌 Yes Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 When (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Dea h Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 \square Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completed filled in by the fu 1 🗆 Yes 2 \square No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and the of certification 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 MD 31. Date filed (Month, Day, Year) State 32. Registrar's Sid Registrar

DHMH 17 Rev 7/2009

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39.	Director		Usual Residence of Decedent							10-2/-1913					NJ	
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Jnn & altimore,	nit. Page 1 artment of i ortant: If it injury or o		4 ☐ Donation 21. Signature of Fur	5 Other (Sp	pecify)		y Cro	ss Cer	meter	ry 🖯	2 27	'-20 10				ton, NJ
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Ö	ospital of hours a neral D	Medical (29a. Certifier	Certifying I	Physician: To the best of	my knowle	edge, death	occured at	the time,	date and p	olace, and	due to the ca	auso(s) a	nd manner s	s stated	
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2/13/10 0315

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 01 2010 Beatrice Moore 10:40 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Crescent Cities Center Riverdale Prince George's Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 1 □ M 2 🛣 F Months Hours 06/07/1917 **Director** 237-12-3898 NC Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 A Yes 2 No MD Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4409 East West Highway 20737 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Black Completed 3 □XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 <u>Homemaker</u> Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ဂ္ Charlie Artis permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Patience Badger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1410 Varnum St. NW Washington, DC 20011 <u>Yvette O. Dill/Guardian</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cem. 02/15/2010 Suitland, MD 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 9th ST NW Washington DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Arteriosclerotic Cardiovascular Disease Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or às à consequence or). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year a 🗍 Unknown 9 Unknown certificate has been signed l rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Peripheal Vascular Disease Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐XNo Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation To the Funeral Director: completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and this 29c. License number 29d. Date signed (Month, Day, Year) D01852 February 3, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Devore

31. Date filed (Month, Day, Year)

MD 4203 Oueensbury RD Hyattsville MD 20781

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death KAYOLA JEAN McCARTER Physician/ FEBRUARY 2010 8:21 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GILCHRIST CENTER TOWSON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 -XF Months Days Hours Month Day Y Director SOUTH DAKOTA 503-30-3301 74 Usual Residence of Decedent show ral", or items 23a or 28a-f shore Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD CARROLL SYKESVILLE 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21784 6602 CARROLL HIGHLANDS ROAD USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify: "natural", 3X Widowed 4 □ Divorced Specify: WHITE Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12TH GRADE KEY PUNCH OPERATOR **UPS** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 MARCUS PATRICK LALLEY MINNIE BARBARA ASSMUS of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LISA WARD/DAUGHTER 209 WEST LANDALE STREET BALTIMORE, MD 21217 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) MORGANTON CEMETERY 2/20/2010 GREENBACK. **TENNESSEE** 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility MO1139 THE JOHNSON FUNERAL HOME, P.A. LOCH RAVEN BLVD. TOWOSN. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-transi the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Director: After this certificate has perform 2 🗌 No 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗷 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending injury 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one FEBRUARY 16, 2010

State Registrar PLES ST, SUITE 4105 BACTIMOTEMB 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 1 9 2010

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04530 State of Maryland / Department of Health and Mental Hygien® 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 0635AM obert Moody 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Vorthwest HOSPItal Randallstown Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | A A(Month, Pay, 7. Age (In yrs. last birthdav) 9. Birthplace (State or Foreign North Carolina Social Security Number 6. Sex **Funeral** Months 237-36-4410 Usual Residence of Decedent 1 XM 2 □ F Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Madical Evantinat must be natified at annear. 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 □ No Funeral Director more 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Completed by 3 Widowed 4 □ Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mood VIDOCE 2 19a. Informant's Name/Rela ionship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ave. Ito. Ma 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease on Figury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d, Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2ŪNo his certificate has b I director, page 2 sl 24a. Was an à No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Matural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. and title of certific 29b. Signatur 29d. Date signed (Month, Day, Year) 106265 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old COUY+ Randollstown anveer (701b 31. Date filed (Month, Day, 32. Pegistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 506 A M RALPH MARLOW 17,2010 February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Y Georgia 1**∑** M 2 □ F Hours Director 257-40-8607 1922l Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maryland | Harford Joppa 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1028 Ensor Drive 21085 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. item 27 is marked other than "natural", or other traumatic event, the Medical Exami 1 ☐ Yes 2 No Specify. Specify. 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Master Sargeant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arch Howard Marlow Lizzie Maude Conner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trat once. Linda C. Marlow / Wife 1028 Ensor Drive, Joppa, MD 21085 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial 2-24-10 Fallston, Maryland 21. Sign Jugar 1 Full ral Serv 22. Name and Address of Facility McComas Funeral Home, P.A. 317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) cute Respiratory -alluce Medical Due to (or as a consequence of): **Examiner** 0651 Jack Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a c sequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day ed by the a g Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ deconditioning Tleocolic Resection Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an tis, Chronic blend from colon has autopsy perform **Director:** After this certificated in by the funeral director, pag Anastomotic ter small bowel resection Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natura. Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) DO053563 rson who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

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OMPSON MD

32 Registrar's Signature

FEBRUARY

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2016 6:15 Рм Sewall Mann Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium Stella Maris Hospice Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏝 F Months Davs Hours uly 31, Year) 30 New York Director 79 457-62-4703 Usual Residence of Decedent show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director MD Baltimore Lutherville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2525 Pot Spring Rd 21093 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. white Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2**X** No 1 ☐ Yes 2 K No Specify: 3 🛮 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) office manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John Kunkland Weeks Geraldine Boardman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Louise Headock/daughter Rosemont Lane; Briarcliff Manor, NY 10510 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4X Donation 5 ☐ Other (Specify) Signatur na 1 rvice Licensee Virector State Anatomy Board; 655 W. Baltimore Street -Baltimore, Maryland 21201 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. STOMACH CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of,: attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an nas autopsy performed? Yes 2 X No certificate h 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Director: After this 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours after To the Funeral Direc City or Town, State edical 29a Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 K Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Minth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State FEB 19 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 7/2009

	- 10		For State Registrar	State of	Marylan		rtment of l	Health and N	•	giene Reg. No. 2	010	04533
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			Holy Cross					Spring				ry Co.
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 🛣 F	7. Age (In yrs. i		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th i <i>y, Year)</i>	9. Birthpla Count	ace (State or Foreign ry)
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	and		10a. State 10b. County		10c. City	y, Town or Lo	ation		·		10	d. Inside City Limits
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Division of Vital Records,	or Att ter de irecto	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be nined 28e. Place of building	of Injury - At ho g, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (City or Tox	Street and Nur vn, State)	nber or Rural	Route Number,
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	_	-	30. Name and address of person	who completed cause	of death (Itom	23a) (Time F						
	3		Sirak Hago	s Lemura	- 150	00 For	est Gle	en Rd.,	Silver	Spri	ng. M	d. 20910
	Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signat	ture	-					
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	o Be	19a. Informant's Name/Relationship (Type, Print)		o. Mailing	Address (Stree		or Rural Route Nu			, Zip Code)	
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Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Pla	ce of Injury - At home, fa	arm, street	, factory, office b	uilding, etc.	28f. Location or Town,		and Number or Ru	ral Route Number, City	
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6		 Name and address of person who completed can Margarita Korell MD. Assistant Me 	se of death (Item 23a) dical Examiner	111 Pe	nn Street, B	altimore, M	1D 21201				
	ate	31. Date filed (Month, Day, Year) /32. R	egistrar's Signature				-				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Claire Marilyn Norjen ebruary M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Days Min. May 25, 1930 New Jersey Director 217-26-2453 79 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Marvland n/a Baltimore 1XX Yes 2 No 10e. Street and Number 5 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 214 E. Melrose Avenue 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🄀 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or ite Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 n/a Broker Rowe Price Be t. Page 1 and 2 should be filed rtment of Health and Mental H. rtant: If item 27 is marked otl njury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clinton Charles Norjen Anna Edna Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Michael D. Higgins (Nephew) 3025 W. Cold Spring Lane Baltimore, Maryland 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 5 Other (Specify) Dulaney Valley Mem. Gdns. 2/19/2010 Timonium Maryland 4 Donation 21. Signatur of nerri Service 22. Name and Address of Facility 21204 Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled. Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Dav Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Y Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ြု 1 Tyes 2 **N**aNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 1 Natural 28d. Describe how injury occurred injury 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signaty License number 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

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FEB 19 2010

Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 0'Hare Michael Bernard 3:49 PM EFR 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Good Samaritan Hospital Baltimore City N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 □ F Months Days Hours. Min. (Month, Day, Year) 054-18-5071 Director 86 1923 16, Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Dunda1k 1 ☐ Yes 2 🎇 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8034 Kavanagh Road 21222 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: and Mental Hygiene. is marked other than "natural", Specify: 3 V Widowed 4 Divorced Year or Dates WWII White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore Gas Elementary/Seconday (0-12) College (1-4 or 5+) 11 Years Electric Commerical Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ John Henry O'Hare Annie Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 21028 3211 Whitefield Road Churchville, MD Kevin J. O'Hare (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Sacred Ht. of Jesus Cem. 2/22/2010 Dundalk, MD 4 Donation 5 DOther (Specify) 21. Sign ture of Funeral Service Lice Duda-Ruck Funeral Home of Dundalk, Wise Ave. <u>Dundalk</u>, <u>Maryland</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ STROK disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death Month g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION, HYPERLIPFDEMIA 1 Nes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificate has builtector, page 2 sl autopsy perforn 2 No 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2V No Other: 1 🗌 Yes 1V Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Funer completed fil 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie Satistkaben MD 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

OHARE

LOCH RAVEN BOULEVARD BALTEMOREMD 21239

KABRA 5601

32. Degistrar's Signature

SATISH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 15 7:45 a M 2010 4c. County of Death 4a. Facility Name (If not institution, 4b. City. Town, or Location of Death Towson Balto Manor Care 8. Date of Birth (Month, Day, Year) 7-3-1944 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1**☆** M 2□ F Months Days 65 MD 218-44-8902 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 XYes 2 No MD na Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 305 E. 21202 SA Lafayette Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 **X**No Never Married 2 Married Black 1 ☐ Yes 2 ☐ No Specify. Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th grade Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Larry Odorns, Sr Ora Anne Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 E. Lafayette Avenue Balto, MD 21202 Harold Banks-Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Pk 2-22-2010 Randallstown, MD King 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H Druf-mile 21202 1101 E. North Avenue Balto, MD 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or heart failure. List only one cause on, ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Did to (or as Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Onknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he nortified at

Baltimore, Maryland 21215-0036

requires that the death certificate be executed as the burial-tra physiciar

Box 68760

σ.

Division or Vital Records,

Physician:

the Hospital or Attending

death.

Examiner Physician/Medical use for the s been signed by the should be detached þ Completed has page 2 certificate funeral director, Be P this Certification: After within 24 hours after death

To the Funeral Director:
completely filled in by the f

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy performed Yes 2 1□ Yes Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA

26. Place of Death (Check only one) Other: 4 Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death? 1 ∐Yes 2 No

Manner of Death 1 Natural 5 Pending 2 Accident 3 Suicide 4 Homicide

29a. Certifier

(Check only one)

25. Was case referred to medical examiner?

1 Yes 2 No

28a. Date of Injury (Month, Day Year) Injury investigation Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sign and title of certifier

29d Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print) led (Month, Day, Year,

State Registrar

DHMH 17 Rev 1/2001

28b. Time of

10-01094 UNK UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physici	ian/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Deat	eg. Noh	3. Time of Death
edical Exam		Damien Osacoca	Month February 6	Day Year 5, 2010	1947 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat	th	4c. County of Deat	n
		St. Agnes Hospital Baltimore	la a	1	
Funeral Director		5. Social Security Number VAK 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr Months Days Hours Min	_	h(MM/DD/YYYY) 9. Bir Forei	
	ŀ	Usual Residence of Decedent	9-20	-1986 c	ountry Ghana
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
		MD Baltimore Windsor Mills			1 Yes 2 No
Maryla 28a-f d at ou	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	ntry?
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.	喜	7503 Silbert Lane 21244		Ghana	
th wit cems 2 it be n	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerte		14. Race - Amer White, etc.	ican Indian, Black,
er dea		1 Yes 2 No No specify:	,	2	1 aV
nore, MD 21215-0036 ages I and 2 should filed within 72 hours after nt of Health and Meula Hygiene. It If them 27 is marked other than "natural", other traumatic event, the Medical Examiner.	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	work done	Specify: 16b, Kind of Business/	Industry
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5-0036 iled within 7 Hygiene. I other than the Medica	ᇤ	2 Care Giver		Care from	m the Heart
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2121 ould be fi Mental I marked c event,	o Be	192_Informant's Name/Relationship (Type, Print)/ 19b. Mailing Address (Street and Nu ber or		ah	7:0:1)
MD 2 Id 2 shou lith and M m 27 is n	ř	Robert Duah / Father 7503 Jilbert K	ane h	1.	i zip code) I; I/S MO J/XA
e, N and 2 Health item 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I an Department of Hea important: If ites		1 VBurial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:	20 2010	Ballin	. 2 - 0
Baltimo permit. Page Department of Important: injury or oth		4 Donation 5 Other Specify: Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	27-2010	Dal Fine	ral Services
iai iai per an		Vaugho C. Dune 8728 Liberty Rd		alkdown, MD	
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Examiner		Immediate Cause (Final disease a. Multiple Sharp Force and Blunt Force Injuries			Death
		or condition resulting in death) Due to (or as a consequence of):			
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	Examine	(Disease or injury that initiated events resulting in death). Last events resulting in death). Last			
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Box e death the atter ed for u	ysic	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown		Ï	
0 - 0		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
Division of Vital Records, P.O. at or attending Physician: The law requires that the ris after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	d by		1 Yes	2 No 3 Prob	ably 4 🗹 Unknown
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He law ate has age 2 sh	Completed		perform	ned? death?	_
Vital Rechysician: The lithis certificate lidirector, page	υ	25. Was case referred to medical examiner?			
Vit hysical this c	To B	1 Yes 2 No Indicate 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursin		Residence 6 Other	:
ding Ph	Ë	27. Manner of Death 28a Date of Injury (Month, Day Year) 1 Natural 5 Reading Feb 6, 201 1 1853 hrs 1 Yes 3 M No.	28d. Describe ho Subject assa	ow injury occurred ulted	
Vision or Atteno fiter death Director: in by the	aţi	2 Accident Investigation			
Division /	Certification:	3 Suicide 6 Could not be determined (Specify) Street	or Town, Sta	reet and Number or Ru ate)	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier Devision To the heat of my knowledge death and the first the heat of my knowledge death and the		usétts Avenue, Baltin	
thin 2.	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
To vii	Me	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mor	nth, Day, Year)
		Theodor III To The IV. O.C.M.E. O	ICME	February 8, 2010	
0.1	ł	30. Name and address of person who completed cause of death (Item 23a)			
J V		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore	e, MD 21201		
St	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature—			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary E. O'Connor Feb 1 6ªy 20^Yfab 12:55A M Medical 4a. Facility Name (if not institution, give street and number) 4h City Town or Location of Death **Examiner** 4c. County of Death Bethania Assisted Living Westminster Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign, Maryland 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 F Months Days Min. Hours 214-01-2249 95 Director Yrs Usual Residence of Decedent or 28a-f shov notified at shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Finksburg 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 1932 Carrolton Rd. 21048 USA and 2 should be filed within 72 hours after death v Health and Mental Hygiene. tem 27 is marked other than "natural". or items 12. Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, et Completed by 1 Never Married 2 Married Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced th and Mental Hygiene. 27 is marked other than "natul traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Social Security Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Michael Kreiner Viola Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Kathleen M. Little-daughter 2030 Dennings Rd. New Windsor, MD 21776 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 2-19-10 Sykesville, MD 4 Donation 5 Other (Specify) View Memorial Lake 22. Name and Address of Facility Fletcher Funeral Home homas 7 254 \mathbf{E} St., Westminster, Main 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No 1 Yes 2 2 Unknown sate has been signed by the a page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? ours after death.

eral Director: After this certificate filled in by the funeral director, page 1 Yes 2 No 1 Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Other: Certificate: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Num) 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) ddress of person who completed cause of death (Item 23a) (Type, Print) mb 31. Date filed (Month Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 8:04 AM Dolores Μ. Paesch Feb 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8898 Avenue B Edgemere Baltimore Co. If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) OV • 16,1911 1 ☐ M 2**X**XF Months Country) Maryland Director Yrs 213-05-6084 98 Nov. Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits death with the Maryland Director MD Baltimore Edgemere 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21219 United States 8898 Avenue B 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: "natural", Completed 3 X Widowed 4 Divorced White Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Years <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Carmino Dambrosia Mary Tatta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8898 Avenue B Edgemere, Maryland 21219 Janet Prechtel(Daughter) 20a. Method of Disposition 20b Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 2 Cremation 3 Removal from State ↑ Other (Specify) reland Mem. Park Cem. 2/19/2010 Baltimore, Maryland Signature neral Servi ^{22. Name and Address of Facility}
Duda-Ruck Funeral Home of Dundalk,
7922 Wise Ave. Dundalk, Maryland Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each live. Approximate Interval Between Onset and Death Immediate Cause (Final reiner Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** UARIAM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of: Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown P.O. | signed I Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending injury work?
1 ☐ Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month

istrar's Signature

Kenneth Williams,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carolyn Pod1es Marie 2010 7:40 P Feb Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5 Bellington Court Nottingham Baltimore Co. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 🗆 M 2 💢 F Months Davs Hours Min. Country) Maryland 69 Director 219-38-9383 1942 Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Dundalk 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 704 S.Old North Pt. Road 21224 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ğ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔯 No Specify: Specify 3℃Widowed 4 □ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Store Deli Manager 12 Years permit. Page 1 and 2 should be filed Department of Health and Mental Hyr Important: If item 27 is marked other any injury or other traumatic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Helen M. Poturalski Joseph G. Stanofski, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Jankowiak (Daughter) Baltimore, Maryland 5 Bellington Ct. 20b. Place of Disposition (Name of cemetery, crematory or other place Holy Rosary Cem. 20a. Method of Disposition 20c. Location - City or Town, State 1 🛣 Burial 2 🗆 Cremation 3 🗆 Removal from State 2/22/2010 Dundalk, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, . Signa gre of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland 1 F ter the disease, or complications that caused the ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Multiple Mg disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Linter underlying Cause (Disease or linjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical P.O. Box 68760 attending ph for use as th IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 1 ☐ Yes ∠ a g ☐ Unknown been signed by the should be detached a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, discase 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 24 hours after death.

Funeral Director: After this certificate has page 2 autopsy performed? 2 🗆 No 1 Tes **Division of Vital** 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural
2 Accident
3 Suicide
4 Homicide Hospital or Attending 5 Pending work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 00058893 30. Name and address of person who completed cause of death (Item 23a), (Type, Print) Eastern 4740 1. Browner 31. Date filed (Month, Day, Year) FEB 19 32. Registrar's Signature State Registrar

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	ysicia Medic		Registrar 1. Decedent's Name (F	First, Middle, L	ast)	Virg	ini		Pea		Jean		2. Date of De Month		year Year		Time of Death 8:41 AM
E	xamin 	er	4a. Facility Name (if not Social Security Number 1)	amak		Hos		ast birthday)	B	y, Town, o	mor	n of Death	ND. 8. Date of Bi	rth 4	c. County of De	ath	E CITY e (State or Foreign
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15-0036 72 hours after death with the Maryland	ed oner man "natural", or nems zoa or zea-f sno event, the Medical Examiner must be notified at	۾	11. Marital Status 1 ☐ Never Married 3 🌠 Widowed 4 ☐		Arı 1 1 [as Decedent Emed Forces? Yes 2 1. Yes, Give X X ar or Dates.			If Yes, sp	edent of H ecify Cuba 2 No	an, Mexic	an, Puerto F	cify Yes or No Rican, etc.)		14. Race - An Black, Wh Specify: B1	ite, etc.	,
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Baltimore, permit. Page 1 and Department of Hea	ury or oth	ij	20a. Method of Disposi	Cremation 3	☐ Remov	al from State	Ki ^c	Place of Dispo emetery, crer ng Me	nsition (Na matory or MOL	ame of other place Lal	Pk		ate -2010		ndalls		
Balt permit Depart	any injury once.		21. Signature of Funera	al Service Lice	nsee					and Addre		·····y	arch venue		t F/I		21202
Physi	cian,		23a. Part 1. Enter the c shock, or heart fa Immediate Cause (Fina disease or condition resulting in death)	ailure. List only	one caus	e on each line	515		er the mo	de of dyin	g, such a	as cardiac o	respiratory a	rrest,		Inte	proximate erval Between set and Death
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executed	transit	xaminer	Sequentially list condit if any, leading to imme cause. Enter Underlyin Cause (Disease or impor- that initiated events	ng ury	c	Due to (or as a	a consequ	uence of):									
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Division of Vital Rec to the Hospital or Attending Physician: The la within 24 hours after death.	e funeral d	cate: T	27. Manner of Death	Pending		a. Date of injuite (Month, Day	ry	ER/Outpatier 28b. Time of injury	7	28c. Injun work	y at	2	ne 5 ∐ Resi 8d. Describe		6 Other (Sperry occurred	ecify)	
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ne Hospit in 24 hour	pleted fille	Medical Certificate:	(Check 2 📙	Medical Exa	miner : On	the basis of e	kaminatio	and/or invest	tigation, ir	my opinio	on, death	occurred at	he time, date	and plac	and manner as s e, and due to the (s) and manner a	e cause(s) and manner stated.
V vith the	Eoo		29b. Signature and title		unk.	-Wos	ORMU	, mo	29	c. License	e number				ate signed (Mor		
V			30. Name and address						Print)) 51	(d)	Lock	POVE		Blvd		239
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Middle, La.	st)			2. Date of Dea		3. Time of Death
	Physici /Medi		JANIE		Pos	EY	FCB Month	13 2010	11:26 PM
	Examir	er	4a. Facility Name (If not institution, giv NORTHAMP TON	*		City, Town, or Location of D		4c. County of Dea	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday) If	Under 1 Year If Under 24		_	thplace (State or Foreign ountry)
	Director		2/5-32-/3/7 1 Usual Residence of Decedent	□M 27 F 98	Yrs.	Julia Days Flours	NOV II,	1911 FX	LOER KIR ME
	ryland how	_	10a. State 10b. County		ty, Town or Location				10d. Inside City Limits
	he Ma 28a-f s	ecto	MO FREDER	21.CR PR	to to li				1 Yes 2 No
	23a or 2	Funeral Director	10e. Street and Number 418 CARROUT	DN DR.	1	0f. Zip Code 21761		10g. Citizen of What Co	ountry?
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Maritest Eventinar must be rediffied at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 □ No If Yes, GiVe Year or Dates:	1	Decedent of Hispanic Origin's, specify Cuban, Mexican, Profes 2 No Specify:	? (Specify Yes or No- uerto Rican, etc.)		
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Mar	d 2 sho Ith and I III		19a. Informant's Name/Relationship (Idress (Street and Number of			
ore,	permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition	20b. F	Place of Disposition		Date	20c. Location - City or	
altimore,	t. Page rtment rtant: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	5m	MBBUR	G CROM. Feb	19,2010	SMATTSBU	RG MB.
Bal	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licen	Kollins	110	me and Address of Facility	ST FRED 6	RICIR MD	21701
	Dharistan		23a. Part 1. Enter the disease, or companies shock, or heart failure. List only Immediate Cause (Final	lications that caused the death one cause on each line.	h. Do not enter th	e mode of dying, such as car	diac or respiratory and	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequ		en's den	rendia		
	Examiner	er	Sequentially list conditions,	b					
	outed ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence or;				
68760,	ficate be executed physician and s the burial-transit	sal Ex	resulting in death) Last	Due to (or as a consequent	uence of):				
_		Medical	IF FEMALE:	d					
.O. Box	law requires that the death certif as been signed by the attending 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	il death 3 ☐ Ect	opic pregnancy er (specify)		23d. Date of de Month	livery Day Year
s, P.	w requires that s been signed b should be deta	by Pt	Part II. Other significant conditions of	ontributing to death but not resi	ulting in the underl	ying cause given in Part I.	23e. Did to	bacco use contribute to	
ord	requir been s should		Hyperlen	ann M	Cully	un ulce	1 T		robably 4 🗌 Unknown
of Vital Records,	The law cate has page 2 s	Completed			- 306		— 24a. Was a autops perfor	sy prior to med? death?	utopsy findings available completion of cause of
/ital	Physician: The lav this certificate has ral director, page 2	BeC	25. Was case referred to medical examiner?			26. Place of	1 □ Yes (Death <i>(Check only or</i>		s 2□No
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ion	Attending r death. sctor: After by the funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	28c. Injury at Work? 1 □ Yes 2 □ No	250, 2550135 1	on injury occurred	
Division	al or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specifi	ome, farm, street, f	actory, office	28f. Location (S City or Town	treet and Number or R n, State)	ural Route Number,
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my kno liner: On the basis of examina and manner stated.	owledge, death occurring and/or investi-	urred at the time, date and p gation, in my opinion, death o	lace, and due to the occurred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	(1)1 A	1//	29c. License number	(6)	29d. Date signed (Mont	th, Day, Year)
		-	20 Name and ordered of the second	Sylvery of doctor	76 M20	1351	5 5 4	Muany	14,2010
			30. Name and address of person who o	on the leading of death (Item	23a) Clype, Print	so wast &	The Stre	of Fred	Perich MI
	Sta Registra		31. Date filed (Month, Day, Year) FEB 19 2010	72. Registrar's Signa	ture	,		,	

DHMH 17 Rev 1/2001

Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MATTHEW MORTON PENN 2-45 PM 02 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CZR BALTIMORE CITY BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sev **Funeral** 1**∑**M 2□F JUNE 13,2009 MD Director 30 215-85-2375 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Director BALTIMORE DUNDALK 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Completed by Funeral 1613 FOUR GEORGES CT. APT. B1 21222 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes Year or Dates: , or 1 Never Married 2 Married 1 ☐ Yes 2 TNo Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 NEVER WORKED nt of Health and Mental Hyg If Item 27 is marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 'nent of Health and Mental CRYSTAL ELLEN BURDETTE ပ EARLE MORTON PENN, III 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1613 FOUR GEORGES CT. BALTIMORE, MD 21222 CRYSTAL PENN/MOTHER permit. Pages 1 am Department of Heal Important: If Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 02/19/2010 . 1**∑P**eurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) OAK LAWN CEMETERY 2-18-2010 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 9 morton ames 1701-31 LAURENS ST. BALTIMORE, MD 21217 23a. Pan I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIAC ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LIVER FAILURE Sequentially list conditions, and the last translation of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner al or Attending Physician: The law requires that the death certificate be executed after death.
I Director: After this certificate has been signed by the attending physician and RESPIRATORY FAILURE burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DOWNS SYNDROME 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown BOWEL RESELTION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy TRACHEOSTOMY 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 Natural 1 ☐Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 02/12/2010 29b. Signature and title of certifier 29c. License number Shelle Moorthy, MD. 19762 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHEELA MODRTHY, MD 29. S. GREENE ST, BALTIMORE; 21201, MARYLAND.

State Registrar

FFR 1 9 2010

31. Date filed (Month, Day, Year)

32. Registrar's Signature

21215-0036

Maryland

Baltimore.

P.O. Box 68760,

Division of Vital Records,

Junius Eugene Parris

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 04545
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		1- For State Registrar		Cei	rtificat	e of i	Death				R	teg. No.			
Physicia		Decedent's Name (First, Midd	le,Last)							2.	Date of Dea		Year		3. Time of Death
ical Exami		JUNIUS	EUGENE	PARRIS							Month February	Day 14, 201) rear		1217 hrs
		4a. Facility Name (if not institution				4b	. City, Town	n, or Lo	ocation o				ounty of	Death	
	Ì	1425 Bond Street					Baltimor	е					N/A	A	
C		5. Social Security Number	6, Sex	7. Age (In yrs. I	ast birthda	av)	If Under 1	Year	If Unde	r 24Hrs.	8. Date of B	rth(MM/DE			nplace (State or
Funeral Director		o. Goodal Gooding Hambon		,				Days	Hours	$\overline{}$				Foreign Cou	MARYLAND
Director		219-18-8941	<u>X</u> XM 2∏F		84	Yrs.					08/02	/1925			111 97
> -		Usual Residence of Decedent		Idon City	, Town or	Lanatio									10d, Inside City Limits
e *		10a. State 10b. County		Toc. City											1 X Yes 2 No
shover and	Ӹ	MARYLAND N/	A		BA	LTI	MORE								
ne Maryland or 28a-f show any ffed at once.	핞	10e. Street and Number					10f. Zip Co	de				10g. Citize	n of Wha	at Count	ry?
he N iffed	Director	4104 SPRIN	GDALE AVE	NUE		I	21.	207				U.S	5.A.		
with the s 23a c noti		11. Marital Status	12. Was De	cedent Ever in U	.S. 1						ify Yes or N	0- 14			an Indian, Black,
eath wil items	uneral	1 Never Married 2 XX	larried Armed F	Forces?		If Ye	s, specify Co	ıban, I	Mexican,	Puerto Ri	can, etc.)		White,	etc.	
re de	╙	3 Widowed 4 Div	orced If Yes, Give Ye			1 \	Yes 2x	No	specify:			S	ecify:	BLAC	CK
rs af ural	ð	15. Decedent's Education (Spe	or Dates:				s Usual Occ					16b. Kin	d of Bus	iness/In	ndustry
2 hou "nat	eted	Elementary/Secondary (0-12)		1-4 or 5+)	dui	ing mo	st of working	life. C	DO NOT	use retired	d)				
36 iin 73 han dical	ple			,	,	סדעי	PER					COL	PER	S	;
Mer 1	ompl	11th grade 17. Father's Name (First, Middle	Last)		L)11 T T	LEK	18	3.Mother	s Name (F	irst, Middle,				
filed Hy	o e	EUGENE PARR							P	ESST	E TATE				
21215-0036 Muld be filed within 72 hours after that Hygiene. marked other than "natural", cevent, the Medical Examiner.	Ď	19a. Informant's Name/Relations			19b I	Mailing.	Address (5	Street			ral Route Nu		or Town	. State.	Zip Code)
D 2 shou and N 7 is n	Ĕ														yland 21207
MD and 2 sho alth and 2 is raumati		Trinna L. Parri	s/Daugnte	20h			ion (Name o				Date				Town, State
S la of He of Tite		1 X Burial 2 Cremation	n 3 Removal		crematory				,					,	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, ment of Health and Mental Hygiene, in the Maryland fixed other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other S			RRIS	ON F	OREST			03-0	1-2010) OW:	INGS	MII	LLS, MD.
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If tiem 27 is marked other thinjury or other traumatic event, the Med		21. Signature of Eureral Service				22. Na	me and Ado	ress c	Facility	IN CO	тинт	יווד צי	JERA	T. H(OME P.A.
W F V W II		after	Danue			1.2	206 W	NOR	CTH P	VENU	E				
Physician		23a. Part I. Enter the disease, or failure. List only one cause		caused the death	n. Do not e	enter the	e mode of d	ying, s	uch as ca	ardiac or r	espiratory ar	rest, shock	, or hea	rt	Approximate Interval Between Onset and
/ /Medical		Immediate Cause (Final disease	A46 - 40 0 0 1 -	erotic Cardiov	vascula	r Dise	ase								Death
Examiner		or condition resulting in death)		a consequence of						_					
		Sequentially list conditions,	b												
	ner	if any, leading to immediate cause. Enter Underlying Cause		a consequence	of):										
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nsi ed 📉	Examiner	events resulting in death) Last	Due to (or as	a consequence (J. 1.										
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cat cat	/W	IF FEMALE: 23b. Was decedent pregnant in t		, outcome of preg birth		Fets	al death	3	Ectopic	pregnan	CV .		onth		ay Year
Box 687 he death certiff to the attending hed for use as 1	Physiciar	past 12 months?		nant at time of d		=	er (Specify)								
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cords, law requir has been s	ple											opsy ormed?		rior to co eath?	ompletion of cause of
Rec The Is cate h	E											2 🗸 No	1	Ye	s 2 No
tal Rection: The certificate ector, page		25. Was case referred to medica	al		-		26.			(Check or					
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of \ ing Phy After th uneral	-	27. Manner of Death	28a. Dat	e of Injury th, Day, Year)	28b. Tir	ne of In	jury 28c	Injury	at Work	? 2	8d. Describe	how injury	occurre	ed	
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ISIC Atte r dea ecton	cat		estigation 28e. Pla	ce of Injury - At I	nome, farm	n, stree	t, factory, of	ice bu	ilding, et	c. 2	8f. Location	(Street and	Numbe	er or Ru	ral Route Number, City
Division of Vital Records, spital or Attending Physician: The law require ours after death. There this certificate has been si filled in by the funeral director, page 2 should be	Certification:	dete	ild not be ermined (Specifi								or Town,	State)			
- id on a lit		4 Homicide 29a. Certifier 1 Certifying F	Physician: To the be		dae deeth	OCCUPY.	ed at the tim	e dat	e and pla	re and d	ue to the car	ise(s) and	manner	as state	ed.
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To the within 2 To the Complet	led	2 🖳	and manner	stated.					number						nth, Day, Year)
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1		30. Name and address of perso					12. 141								
		Ling Li, MD Assista	ant Medical Exa				t, Baltimo	re, N	/ID 212	201					
	tate	1 d () 001	32. 1	Registrar's Signa	ture		6								
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 04546 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9.09 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner more 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 - M 2 X Months Hours Min. Month, Day Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 X Yes 2 ☐ No more 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. ğ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked 19a. Informant's Nahe/Relationship (Type, Print) Grandaught 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State any injury or 2/23 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Fa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Approximate Lerval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transi Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ending physician are use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy for Month Dav Year Pregnant at time of death 5 Other (specify) certificate has been signed by the a irector, page 2 should be detached f P.O. 23e. Did tobacco use contribute to the cause of death? Š Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performe 1 🗌 Yes 1 🗌 Yes 2 🗆 No Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Dat signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Pasterfield Roland Rbruary 2010 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Mare C05 0 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, . Age (Inlyrs. last birthday) **Funeral** Days Months Hours 1 X M 2 □ F 220-22-6249 Director January 3, 1929 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Item lical Examiner must be notified at 1 ☐Yes 2 XNo Director Maryland Baltimore Dundalk 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USA 7029 Eastbrook Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married White 1 ☐ Yes 2 No Specify: Maryland 21215-003 þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Railroad Conductor years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be Health and Mental Katie Kitlet Joseph Pasterfield ပ ו | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) י בייים בייים אונים אונים ביינים אונים אונים ביינים ביינים אונים ביינים בי 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any injury or other trau 7029 Eastbrook Avenue, Dundalk, Maryland Eva Pasterfield wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory 20, 2010 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. Signature of Funeral Service Licenses 7110 Sollers Point Road, Dundalk, Maryland 21222 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of) Examiner 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clasase of Ir Ju.) that initiated events resulting in death) Last Tue to (or as a consequence of) Examine Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month in the past 12 months? Day Ye ar 5 Other (specify) signed by the a 1 ☐ Yes 21 No 9 ☐ Unknown P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ≥ 2 **N**O 3 Probably 4 Unknown 1 Tes Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page certificate 1 □Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Iniury 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 9 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1220. MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Naveer

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

19 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February Pishalski 2010 8:10 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1211 S. 48th Street Dundalk Baltimore 8. Date of Birth (Month, Day, Year) Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 √2 M 2 □ F Months Davs Hours Director 218-18-9283 86 tober Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore Dundalk 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1211 S. 48th Street 21222 USA Was Decedent Ever in U.S. Armed Forces? 1

✓ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Steel <u>12 years</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Julian Pierzchalski Kazimiera Pierzchalski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James F. Martin Nephew 1211 S. 48th Street, Dundalk, Md. 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1

Burial 2

Cremation 3

Removal from State Februar Gardens Of Faith Rosedale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22, 2010 nature of Furieral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. MULION 23a. Part 1. Enter the disease complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. Lifet Immediate Cause (Final Onset and Death Smal Physician/ disease or condition resulting in death) NOU Months Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, reading to infiniediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of; Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Other (specify) Day Year 2 No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy certificate 1 ☐ Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide injury 5 Pending 2 No Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name 31. Date filed (Month, Day, Year) Registrar's Signature State FEB 1 9 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 2010 Cecil Franklin Petty 2:20 A.M 16. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min **X** M 2 □ F Director 214-26-7291 85 17, 1924 North Carolina Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Moderl Examinar must be nutfled at 1 □Yes 2X No Director Maryland Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1262 Trappe Road 21154 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ™ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 9 Specify: White 3 Widowed 4 Divorced 2 should be filed within 72 hours n and Mental Hygiene.

Is marked other than "natural", Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Artillery Mechanic U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emmet (unk) Petty Nora (unk) Richardson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Ronald C. Petty / Son 3806 Springhill Dr., Havre de Grace, Maryland 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-20-10 Bridge Bapt. Chr. Cem. Rising Sun, Maryland 21. Signature of Mineral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. Ven 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tant failure to thrive Immediate Cause (Final Fxtensive **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury M000059525 Due to (or as a consequence of) Examine physician and s the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Vital 1 □Yes 2 No 1 ☐Yes 2 ☐No Physiclan; funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To ŏ After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending . 0 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Accompletely filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) annan, 69927 10 X1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) bonnan, M.D. 500 upper One Sapeake Dr. Bel Air, M.D. 2101 priati 31. Date filed (Month, Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Richard A. Quarles Jr. 2010 February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year 1 X M 2 □ F Months Hours Min. Country) **Director** 216-34-5122 4-27-1938 Usual Residence of Decedent 3a or 28a-f shov t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 9711 Winands Road 21133 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: African-American "natural". 3 Widowed 4 Divorced Year or Dates and Mental Hygiene.
I is marked other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) US FostalService 12th Motor Vehicle Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be .. Page 1 and 2 should be tment of Health and Menta tant: If item 27 is marked jury or other traumatic e Richard A. Quarles Sr. Geraldine Ware 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice R. Quarles/Wife 9711 Winards Road, Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If it any injury or o 1) Burial 2 Cremation 3 Removal from State King Menorial Park 2-20-2010 Woodlawn, MD Donation 5 ☐ Other (Specify) 21. Signatul of Funeral Service Licens 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. nandou 9200 Liberty Road, Randallstown, MD 21133 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final MUS HATZ Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown is certificate has been signed by the director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe After this certificate Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2010

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

FEB 19 2010

101

N. Charle

DW NOTHER

address of person who completed cause of death (Item 23a) (Type, Print)

10-01170

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mary Nicholas R	_	eway S	tate of Maryla			of Health of Death	and Me	ental Hy			110 0455	
Physici	an/	Registrar 1. Decedent's Name (First, Middenson Nicholas	dle Last) Ridgeway					2	2. Date of Dea Month	Day Year	3. Time of Death	
Medical Exami	ner	MaryNicholas. 4a. Facility Name (if not instituti	Ridgeway	Mary N	lichola	4b. City, Tov	way vn, or Locatio	on of Death	February	8, 2010		
		7509 Ritchie Highway	_			Glen B	urnie		_			
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under		nder 24Hrs. ours Min.		_	Foreign	
Director		282-40-7944 Usual Residence of Decedent	1 M 2X F	64_	,	Yrs.			12/09/1	L945	Year 3. Time of Death 2100 hrs c. County of Death Anne Arundel MDD/YYYY) 9. Birthplace (State or Foreign Country) OH 10d. Inside City Limits 1 K Yes 2 No tizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry anufactory Surname) emple City or Town, State, Zip Code) e, MD 21060 Location - City or Town, State mover, MD tion Services Hanover MD 21.76 Approximate Interval Between Onset and Death Death Death Death Death Death Death Death Death Cuse contribute to the cause of death? No 3 Probably 4 Unknown 24b Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No ence 6 Other Scene	
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0036 within 72 hours after death with the Maryland jone. her than "natural", or items 23a or 28a-f she Medisal Examiner must be notified at once		11. Marital Status	12. Was Dec	edent Ever in U		Was Decedent	of Hispanic (- 14. Race		
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5-0036 led within 72 hours at tygiene. other than "natural the Medical Examin	Completed	17. Father's Name (First, Middle	1	_	Acco	untant	19 Mot)	hare Nama (Firet Middle		ctory	
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MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medica	10	19a. Informant's Name/Relation	ship (Type, Print)				(Street and N	lumber or Ru	ral Route Nun	nber, City or Town		
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E 2 2 5 5		1 Burial 2 K Cremation		om State	crematory or		•		6/2010	Hanover	MD	
Baltimo permit. Page Department of Important: injury or oth	ŀ	4 Donation 5 Other S 21. Signature of Funeral Service		I ALC		2. Name and Ad		zility				
		23a. Part I. Enter the disease, o	5		7	522Conn	elley	Ard Drive	ent Cre , Ste	emation : N., Hand	services over MD 21076	
Physician /M i /		failure. List only one cause	e on each line.		n. Do not ente	er the mode of o	dying, such a	is cardiac of i	espiratory am	est, shock, or hea	Between Onset and	
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lox 68760, leath certificate be attending physic for use as the bur	/Me	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes,	outcome of pre	gnancy			opic pregnanc	04			
Box 68760 e death certificate the attending physical for use as the bu	iciar	past 12 months?	4 Pregn	ant at time of d	eath 5	Fetal death Other (Specify		opic pregnant		Month	Day Teal	
. Boy the death y the att	Physician/Me	1 Yes 2 ✓ No 9 Ur Part II. Other significant condi	tions contributing to	own o death but not	reculting in th	e underlying c	ause aiven in	Part I	23e Did to	obacco use contrib	oute to the cause of death?	
ion of Vital Records, P.O. Box 68760 tending Physician: The law requires that the death certificate lath. or: After this certificate has been signed by the attending phys the functal director, page 2 should be detached for use as the by	<u>ਨ</u>	Faith, Other significant condi	contributing to	dea(ii but not	resulting in t	e dilderlying ce	ause given in	ir diti.				
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Division To the Hospital or Atteno within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only		of examination								
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		/ landa	kell)				D.C.M.E.			February 9,	2010	
		30. Name and address of person Laron Locke MD.	n who completed caus Assistant Medica			nn Street, E	Baltimore,	MD 2120	1			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:15P[™] 2010 February 16 Rolfe Frank David /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Year. Days 1 ☑ M 2 ☐ F Maryland 12/13/1940 Director 213-38-9102 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a. State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Tyes 2 □ No Funeral Director MD Ceci1 Rising Sun 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21911 108 Cooper Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after of and Menial Hygiene.

is marked other than "natural", or ite 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Transportation Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eben Minor Rolfe <u>Isabella Jane Atkinson</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sinent of Health an Anita Dawn Barton / Daughter P.O. Box 921, Rising Sun, MD 21911 Balfimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/19/2010 Hanover, Maryland Anatomy Gifts Registry 4X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Juneral Service Licentee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 5 days **Physician** crebra disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the attending physician and ned for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 1 □Yes 2 □No 9 T Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Abdominal Aprilic Aneurysm 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown myocardeal infarction 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? ueauir 1 □Yes 2XNo After this certificate 1 ☐ Yes il or Attending Physician: 'after death.
Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 | Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10053568 nd address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Dr. etrev 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 280, Maryland Department of Lealth and Mantal Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ZO 10 **Physician** Month CIECIFIC 88 5T DM 28 nue /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BILTIMORE N/A If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 🔀 F 217 52 9037 60 Director 06/20/1949 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland I-lygiene. other than "natural", or items 23a or 28a-f show ent, the "sedical Expression and be putting at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No N/A Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21226 U.S.A. 1511 Cypress Stree Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Hairdresser Beauty Salon permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important; If item 27 is marked other any Injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin White Sr. Dorethea Wenskaitis ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Regiec / Husband 1511 Cypress Street Baltimore, Maryland 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 → Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park | 02/02/2010 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland 22. Name and Address of Facility Gonce Funeral Service 21. Signature of Funeral Service Licensee manuerell wy arrest, which are the control of 4001 Ritchie Highway Baltimore, (Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final FAILURD NULTIOR GAN **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PERITORITI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner SMALL BOWCLI PERFORETED Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à NTRIAL FIBRILLATION 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 ☐ No Division of Vital 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Small bowel 28c. Injury at Work? 1 Nafural 5 ☐ Pending investigation perforation during colpopexy Unknown M 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, fac building, etc. (Specify) Hospital Location (Street and Ny ber or Rural Route Number, City or Town, State) 25 Greene determined 4 ☐ Homicide BALTIMORS, MD within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of contifier



EZ140

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



CORNET

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Albert Romecki Τ. Year 201 10:37AM Feb. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Dunda1k Baltimore Co. 1933 Searles Road Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 1 M 2 D F Days (Month, Day, Year) Sept. 20,1926 Maryland **Director** 83 Yrs 214-22-3653 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director or 28a-f Dunda1k 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21222 1933 Searles Road United States Page 1 and 2 should be filed within 72 hours after death и тепт of Health and Mental Hygiene. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or Completed by 1 Never Married 2 Married XXes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 → Widowed 4 □ Divorced WWII Year or Dates White item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Years Steel Industry Years <u>Accountant</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Barbara Romecki Cecilia Kolakowski Stanislaus James Health and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7909 Wiltshire Court Pasadena, MD 21122 (Niece) Barbara Preston 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 s
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 2/20/2010 Holy Rosary Cemetery 4 Donation 5 Other (Specify) Dundalk, Maryland 21. Signature of Fundal Service Lice Duda-Ruck Funeral Home of Dundalk, Inc. licha 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, ir complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ strictive disease or condition 710 years Medical resulting in death) Due to (or as a consequence of) **Examiner** spest osis > 10 years Sequentially list conditions, if any course of miniscles cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a nonsequence of) physician and the burial-transit or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Year Pregnant at time of death signed by the a 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Mellitus 2 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? y pertension 24a Was an has page performed? Yes 2 No Hyperlipidemia 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a To the Funeral D Hospital Medical 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Manth, Day, Year) HUUS5992 Name and address of person who completed cause of death (Item 23a) (Type, Print) 6730 BAILMOR Holabird L Gallo 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ February 12, 2010 Helen Roumel 11:45 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Collingswood Nursing Center Montgomery Rockville If Under 1 Year If Under 24 Hrs. 6. Sex g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Month, Day, Yea July 10, Days Min 1 □ M 2 🗓 I 578-18-4652 Virginia Director 88 1921 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Directo D.C. Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3901 Windom Place, NW 20016 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🛣 No Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify: White "natural", Specify: Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Radio & Television Business Administrator other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I 2 pe Constantine Stephanos Anna Karavites 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a tant: If item 27 is Angelina Roumel/Daughter Windom Place, NW, Washington, D.C. 20016 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o Fort Lincoln Cemetery February 2010 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) Entombment Brentwood, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 Signature of Funeral Service Licensee M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Acute Stroke Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
g Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ed by the detached g Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed Dementia 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No Yes 2 Z No the Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 🗷 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Z Nursing Home 5 Residence 6 Other (Specify) Director: After this in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Z Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No death. Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Funeral Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted 1 (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of ertifie 29c. License number 29d. Date signed (Month, Day, Year) D0062435 February 16, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Drive, Rockville, Maryland 20850 Sayed Elsayyad, Registrar's Signa State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 04556 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Valerie Ross 19:48PM Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore 7. Âge (In yrs. last birthday) 45 vrs If Under If Under 24 Hrs. 8. Date of Birth (Month, Day Funeral 9. Birthplace (State or Foreign 1 □ M 2 🏲 F Months Days Hours Min. <u>~</u>1964 Director Country) 215-84-9787 MD Usual Residence of Decedent 3a or 28a-f shov be notified at show filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Md 1 X Yes 2 No na Baltimoore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral ral", or items 23a Examiner must b 1422 N. Broadway 21213 IJ SA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", 3 Divorced 4 Divorced Specify: Black other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working nd Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th grade Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ should be Joseph Hall Vashti Ross Department of Health and I Important: If item 27 is mo any injury or other trauma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Vashti Parrish-Mother Broadway Balto, MD 21213 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Zion Cemetery! 2-19- 10 4 Donation 5 Other (Specify) Lansdown, permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility East F/H March 1. 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final) Physician/ disease or condition resulting in death) PNEMONI Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the hurial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant Unknown Pregnant at time of death Month Year the 9 Tinknown ed by t signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown peen certificate has b irector, page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes 2 ☐ No Yes 2: No 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Hospital Other: ျ 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident
3 Suicide after death Director: / d in by the f Investigation 1 Tes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aft

To the Funeral Dil

completed filled in Medical 1º Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year, atist Kales MD 15/2010 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar SATISH KABRA 5601

31. Date filed (Month, Day, Year)

LERI

OCH RAVEN

32. Registrar's Signature

BUD

BALTIMORE MD 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Richburg Lonzer Medical 02 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4810 Norwood Ave Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1**x** M 2 □ F Months Days Hours Min. 1 O 2 Director 250-28-9519 84 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD NA Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 4810 Norwood Ave U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2X No Specify: Specify: Widowed 4 ☐ Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12)

10th grade College (1-4 or 5+) Fireman Oiler CSX na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hunter Richburg Bertha Cain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Evans-Daughter 4810 Norwood Ave, Baltimore, Md 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If its any injury or ot Date 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 2/20/10 Woodlawn, Md 21. Si mature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Av 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause Final Approximate Onset and Death h, sician/ disease or condition resulting in death) MYDEARDIAL INFARCTION Medical Due to (or as a consequence of): Examiner Sequentially list conditions, If any course of the Cause (Disease or iinjury Examine Dani to (or as a nonseque attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Year 4 ☐ Pregnant a 9 ☐ Unknown Pregnant at time of death Month Day 1 Yes 2 9 Unknown the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' certificate 2 No r. After this ceru... Yes 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

29c. License number

21328

SAUTIMORE

29d. Date signed (Month, Day, Year)

10-01299 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Charles Milton Riley State of Maryland / Department of Health and Mental Hygiene 2010 04558 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ Date of Death Month Day February 12, 2010 Medical Examiner Charles M. Rilev 2030 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bon Secours Hospital Baltimore 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country Director Months Days Hours Min 217-66-4171 53 09/02/1956 1 M 2 F Usual Residence of Decedent 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits MD Baltimore Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 42 S. Fulton Ave. 21223 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2. Married White etc. Yes _{Specify} White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: ۾ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) f other than timore, MD 21215-0036 Construction 10 Brick Layer nt of Health and Mental Hygiene.

It: If item 27 is marked other the other traumatic event, the Med 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be John Milton Rilev Louise Minnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Millington Ave. Balto, MD 21223 Dawn Clevenger/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 02/19/ Beltsville, MD Chesapeake Crem. 4 Donation 5 Other Specify 2010 22. Name and Address of Facilit CAFA/Stephen D.Lohrmann P.A 21. Signature of Funeral Service Licenses Green Pastures Dr. Balto. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease and Heroin Intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) Exa events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and transi Physician/Medical ysician a UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, attending physion or use as the bu IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Hypothermia 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26 Place of Death (Check only one) examiner? Other Nursing Home 5 Residence 6 Other After this 1 🗸 Yes 2 No 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural FOUND: Subject took drug and found in a cold Pending 1 Yes 2 ✔ No Feb 12, 2010 1938 hrs environment 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 42 S. Fulton Avenue, Baltimore, Md determined (Specify) Sidewalk 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: If the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) nd manner stated 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 13, 2010

OOME

State 31. Date filed (Month, Day, Year)
Registrar

ss of

Ripple MD.

32. Registrar's Signature

rson who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

strar's signature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-01402 State of Maryland / Department of Health and Mental Hygiene Ricki Joe Roberts Certificate of Death Reg. No. 1. For State 2. Date of Death Registrar Decedent's Name (First, Middle,Last) Month Day February 16, 2010 Year Physician/ Roberts Joe al Examiner Ricki c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Sparrows Point 2840 Lodge Farm Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Hours Months Days November 7,1959 Director 217-78-4363 50 1 X M 2 F Usual Residence of Decedent 10c. City, Town or Location 10b. County any Pylesville Maryland 28a-f show Harford hours after death with the Maryland rector 10f. Zip Code 10e. Street and Number USA 21132 5212 W. Heaps Road $\bar{\Box}$ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 X Married 1 Never Married Yes 1 Yes 2 X No specify: 4 Divorced If Yes, Give Year 3 Widowed "natural", 16a. Decedent's Usual Occupation (Give kind of work done á Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical E Local 16 21215-0036 Ironworker 8 years 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gloria A. Wallace Wilbur E. Roberts Jr. Be 19a. Informant's Name/Relationship (Type, Print) mother Itimore, MD Gloria Roberts 20b. Place of Disposition (Name of cemetery, February 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 20, 2010 Holly Hill Memorial 4 Donation 5 Other Specify. Silvature of Juneral Service Licens Part I. Enter the disea le, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one say to on each line. Physician //Medical a. Infective endocarditis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and AMENDED X UNPENDED 23a,27,permE, g901 3/16/10 TT IF FEMALE: 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify)

Country) Maryland 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? 14. Race - American Indian, Black, Specify: White 16b. Kind of Business/Industry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2840 Lodge Farm Road, Edgemere, Maryland 20c. Location - City or Town, State Middle River, Maryland ²² Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Approximate Interval Between Onset and Death The law requires that the death certificate be executed Physician/Medical attending physician s or use as the burial -23d Date of delivery Box 68760 Year Day 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown Records, P.O. ģ 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of certificate has been autopsy performed? Yes 2 No death? 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: 24 hours after death Funeral Director; After this certifi Division of Vital Other: Nursing Home 5 Residence 6 🗸 Other: Scene æ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 V Yes 2 No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Yes 2 No 1 X Natural 5 Pending Director: d in by the f 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Fund completely f 2 Will Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 17, 2010 O.C.M.E. 30. Name and address of person who can be ed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Russell Alexander MD. Assistant Medical Examiner Registrar's Signature. State Registrar

GRIGINAL

DHMH 17 Rev 1/2001

1003 hrs

Please Type or Printin Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9th, 2010 Ragins 9:00 a Frances Evelyn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Collington Episcopal Life Center Prince Georges Mitchellville If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔀 F 578-42-9473 Director 80 Oct. 4, 1929 SC Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modest Examiner must be notified at 1 ☐ Yes 2X No Director NY New York New York 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 230 E. 88th St. USA 10128 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or itel 1 X Never Married 2 ☐ Married **Black** altimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. ģ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher NY Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Ragins Sally James Ragins ဂ္ 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health a Important: If Item 27 is any Injury or other trau once. Pamela McKay - Great Niece 3308 Carlton Ave. Temple Hills, Md. 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2-19-2010 Alexandria, VA 22. Name and Address of Facility
Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, Md. 20746 Approximate Interval Between Onset and Death Part 1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** Cerebral Vascular Accident weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 TYes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy rmed 2 ☑ No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 -No ၀ 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 and manner stated. 29b. Signature and title of certifier.

State DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Pr lavakoli



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ? 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month ANCES V. STOFANICK 2010 EB. /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KENWOOD TO I Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Hours Months 215-03-0358 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 □No Director MD, 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ENUIDOD AVE 3/221 1.5.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 2/No Completed by 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) is marked other 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 s D. partment of Health an Important: If item 27 is any injury or other trau BALTO, MD. 21224 20c. Location - City 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State OLEN BURNIE 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) eum omia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): SCVI Physician/Medical as attending 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy for t Month Dav Year 5 Other (specify) P.O. ned by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by em ent 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No autopsy performed? 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only ope) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

FERNANDO

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registral's Signature

4NTHEUM

10-01108 Henry Thomas Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	1- For State Registrar	Certificate of Death	Reg. No.	
Physician Medical Examine	HENRY T.		Date of Death Month Day Year February 7, 2010	3. Time of Death 1035 hrs
1	4a. Facility Name (if not institution, give street and nu 203 Trailway Road	mber) 4b. City, Town, or Location Middle River	on of Death 4c. County of Dea Baltimore Co	
Funeral Director	5. Social Security Number 6. Sex 217-37-99// 1/2/M 2 F Usual Residence of Decedent	7. Age (In yrs. last birthday) Ref. Months Days Hou	nder 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Eurs Min. JAW, 1, 1982	
land f show any once.	10a. State 10b. County	10c, City, Town or Location BALTO,		10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.		7. 10f. Zip Code 2/22	10g. Citizen of What Co	-
er death wi	3 Midowed 4 Divorced II Yes Give Year	2 No	an, Puerto Rican, etc.) White, etc.	erican Indian, Black,
2 7 7		e completed) 16a. Decedent's Usual Occupation (Given during most of working life. DO NO	ve kind of work done 16b. Kind of Business	/Industry
215-0036 be filed within 72 ntal Hygiene. rked other than " ent, the Medical.		1	ner's Name (First, Middle, Maiden Surname) AREW SM TH	
MD 212 d 2 should b lth and Meni n 27 is marli aumatic eve	19a. Informant's Name/Relatio hip (Type, Print) DAWN HALL	19b. Mailing Address (Street and N	umber or Rural Route Number, City or Town, Sta みゃ	MD 2/222
altimore, mit Pages I an epartment of Hea pportant: If iter iury or other tra	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal fro 4 Donation 5 Other Specify:	om State 20b. Place of Disposition (Name of cemetery, crematory or other place) ATLANTIC CALM	7-17-10 GLEN	Town, State
Pall Ball Ball Bernit Depart Importing Information Inf	23a Part I. Enter the disease, or complications that ca	22. Name and Address of Faci Skink Da F-H- used the death. Do not enter the mode of dying, such as	KARY HUDSON ST.	MD 21794 Approximate Interval
Examiner	man and a second	ic intoxication consequence of):		Between Onset and Death
nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	consequence of):		
3 5 G T	a	consequence of):		
rial ral	IF FEMALE: 23c. If yes, o	3a,27,28a-f,permE, G900 2	/24/10 TT	
	23h Was decedent pregnant in the	ont at time of death 5 Other (Specify)	23d. Date of delive pic pregnancy Month	ry Day Year
He he he		death but not resulting in the underlying cause given in f	Part I. 23e. Did tobacco use contribute to	C-11-24
			autopsy prior to performed? death?	utopsy findings available completion of cause of
Vital Recysician: The his certificate director, page	25. Was case referred to medical examiner?	Othor:	h (Check only one)	
n of V ing Phys After thii funeral di	27 Manner of Death		Nursing Home 5 Residence 6 10 Others. 28d. Describe how injury occurred	er: Scene
tendin death. stor: A y the fu	1 Natural 5 Pending Fd 2	7/10 Fd 9:30 am 1 Yes 2X		
<u> </u>		of Injury - At home, farm, street, factory, office building, residence	etc. 28f. Location (Street and Number or R or Town, State) 203 Trai Middle River, MD	ural Route Number, City Lway Rd
To the Hospital or within 24 hours afte To the Funeral Discompletely filled in dedical Certif	Certifying Physician: To the best one) 2 Medical Examiner: On the basis of and manner sta	of my knowledge, death occurred at the time, date and p examination and/or investigation, in my opinion, death of sted.		
	29b. Signature and title of certifier Theodore W. King	29c License numbe O.C.M.E.	29d. Date signed (Mc February 8, 201	
	30. Name and address of person who completed cause Theodore M. King, Jr., MD. Assistar	9	altimore, MD 21201	
State Registra		istrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04563 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Staskowiak Month Year Gerald John 2010 Feb Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Johns Hopkins Bayview Medical Ctr. Baltimore City N/A Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 1 🛛 M 2 🗆 F Months Days Hours Min. 69 Director 218-36-7948 Maryland Usual Residence of Decedent show 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Dundalk 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21222 2731 Moorgate Road United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 ☐ Yes 2 ☑ No hours after If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. "natural", Specify Completed 3 X Widowed 4 Divorced White the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Printing Industry Printer 12 Years other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked or မ Leonard J. Staskowiak Anna B. Reitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other 2023 Denbury Drive Dundalk, Maryland 21222 Michael Staskowiak, Sr. (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 2/22/2010 St. Stanislaus Cem. Baltimore, Maryland 4 Donation 5 Other (Specify) Signal of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Munocipidia disease or condition Medical resulting in death) Due to (or s a consequence of) Examiner 17911070 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Dus to for as a conseque Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 phys. attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Year 1 Yes 2 No 9 Unknown signed by the a d be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autons performe Yes 2 No 1 Yes 2 No director Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 100A After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes s after death. 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, by Homicide determined City or Town, State) completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) the 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar 30. Name and a

Jude

31. Date filed (Month, Day, Year)

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Glen Parnie

WD 21061

dress of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 | 1 For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY D SZUMLANSKI 2010 AROLYN 2:05 AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death BAYVIEW MEDICALCENT BALTIMORE JOHNS HOPKINS If Under 1 Year If Under 24 Hrs. ial Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Hours Nov. 15, 1937 Mary Tand Director 215-32-2674 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "...- any injury or other terms." 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Edgemere MD Baltimore 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21219 7007 River Drive Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 Years College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jennie Kaminski Rudolph George Kessler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John J. Szumlanski (Husband) 7007 River Drive Road Edgemere, Maryland 21219 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 2/22/2010 Elkridge, MD 21. Signa are of Funeral Service Licensee 22, Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 7922 Wise Maryland Ave. Dundalk, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death RESPIRATIONY Physician/ FAIWRE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PHEUMONIA Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) UNG Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and defached for use as the burial-transit CANCER that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown been signature Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? Yes 2 2 After this certificate I 1 Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 To မ 1 patient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide Investigation within 24 hours after death

To the Funeral Director:,
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-000 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who com-AVE. BALTIMORE, 21224 GREEN M.D. 4940 EASTERN State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) (1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 6:40 PM **Physician** ORMA ANGLYN 02 llo 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner House AIRY HOSPICE FREDERICK MT If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 🛛 F 099-16-244 NEW Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Expriment mast be notified at 1 ZYes 2 No MY DUTCHESS POUGHKEEPSIE Funeral Director death with the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 12603 HOOKER USA 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes_2 __No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other there any injury or other trainer. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: q Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OMEMAKER Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROSALIE VAUTRIN JACKSON STANLEY ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 217/4 19a. Informant's Name/Relationship (Type. Print) 6012 JEFFERSON Blud, Braddock Hats MD ATHY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 🗖 Removal from State Y Com. 2-22-2010 HURLEY, N.Y.
22. Name and Address of Facility GARY L. ROLLINS FUN. Home E 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses Rollins FREDERICK MO 21701 SOUTH ST Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition emen **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed signed by the aftending physician and de detached for use as the burial-tran-Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No s peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an this certificate has ral director, page 2 : autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 6 Other (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 ☐ Pending investigation spital or Attendii nours after death. neral Director; A death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation is an accordance of the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature DOOBLU3 person who completed cause of death (Item 23a) (Type, Print)

PLUE SU(TE#135)

y, Year) 32 Registrar's Signature -REDERICK, 70-21702 196

DHMH 17 Rev 1/200

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	arylan		artment <i>rtificate</i>			and Me	-	giene	0010	01.566
			Decedent's Name (First, Middle,	Last)					-	2	2. Date of De	ath	- U U	3. Time of Death
	Physici		margaret	m. Shane	,						Month Februa	Da Er Uz	y Year 18, 201	// / / A H M
	/Medic Examir		4a. Facility Name (If not institution,				4b. City, T	Town, or	Location of	of Death	7 0 0 0 0		. County of Dea	ath
			Genesis Multime	dical Center			Tows	son,	Mari	iland	21201	4	Baltin	noce
	Funeral		5. Social Security Number			ast birthday)	If Under 1	1 Year Days	If Under/ Hours	Min. C	B. Date of Bir (Month, Pa ept 16	th Ly, Year)	9. Bi	rthplace (State or Foreign
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	show		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Mary First	ţō	Md. Harfor	d	Fa	llsto	n							1 ☐ Yes 2X☐ No
	h the	Director	10e. Street and Number				10f. Zip	Code	-			10g. Ci	tizen of What C	Country?
	th wit	aiD	1580 Waterva	le Road			210)47					US	SA
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Decede	ent of Hi	spanic Ori	gin? (Spec , Puerto Ri	ry Yes or No can, etc.))-	14. Race - Am Black, Wh	
36	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show he Medical Exercit or could be coeffied at	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🏿 Divorced	If Yes, Give	No		1 ☐ Yes 2	. No	Specify:				Specify: Wh	nite
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212	filed with Hygiene. Ither than	mo	Elementary/Secondary (0-12)	College (1-4or 5	p+)	Book	keeper	•				Воо	kkeepir	ng
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Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 □ Cremation		CE	emetery, crei	natory or oth	her place					ocation - City o	
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Bal	permit. Page Department Important: If any injury o		21. Signature of Finderal Service L	Certise			Ri 10	uck 050	Towso York	n Fu <u>r</u> Rd.	neral Towson	Home , Md	Inc. 21204	1
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Division	al or Attandi s after death. al Director: A ed in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At hor	me, farm, str	eet, factory,	office		28	f. Location (S City or Tox	Street ar	nd Number or F	Rural Route Number,
	tal or	Cert		Nurse Practitie										
	To the Hospital or Attanding within 24 hours after death. To the Funaral Director; After completely filled in by the fune	edical	29a. Certifier 1 ☐ Certifying (Check only one) 1 ☐ Medical E	Physician. To the best of xaminer: On the basis of and manner sta	examinat	wledge, deatl ion and/or in	n occurred a vestigation,	it the tim in my op	e, date and pinion, dear	d place, an th occurred	d due to the l at the time,	cause(s date an) and manner a d place, and du	as stated. ue to the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier				29c.	License	number			29d. Da	te signed (Mor	oth, Day, Year)
)			nuchalle E.	Kalendels C	RNP		4	209	7104			F	ebruaru	. 18, 2010
			30. Name and address of person w	no completed cause of d	eath (Item									
			Michelle E. Kale	ndek Genesi	5 mu	Himed	ical C	ente	1770	o Yor	k Rd.	Tow	500, M.	D21204
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	Les L	20							
	Registr	ar	FEB 1 9 20°	10 Cener	ø.	1900								

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			1 - For State Registrar	State of	Marylar	-	artmen <i>rtificat</i>				ental Hyg	jiene		0	04567
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	/Medic		4e. Fecility Name (If not institution, give			/	4b. City,	Town, or	Location		-ERRUAL	_	County of D	010 Deeth	J. 3 H
			GENESIS FRANK						re Co		.,		Balti		
	Funeral Director		5. Social Security Number 6. Se 213~05~5545	ж _ м Ж Уг ⁷	7. Age (In yrs. 90	. last birthday) Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day AUG. 2	3,19	19	Birthpl Count Mar	ace (State or Foreign yland
	and *		Usuel Residence of Decedent 10a. State 10b. County		10c. C	ity. Town or Lo	ocation							10	Od. Inside City Limits
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	ith the	Funeral Director	10e. Street and Number				10f. Zip		22027		1	l0g. Citi	zen of Wha	at Coun	try?
	Jeath v	eral	1509 Cavel Rd.	12. Was Dece	dent Ever in U	J.S. 13. V	Was Deced		21237 Spanic Ori	gin? (Spe	cify Yes or No-		USA 14. Race - /	America	an Indian,
စ္က	or iter	y Fun	1 Never Married 2 Married	Armed Ford 1 Tes 1 If Yes, Give			lf Yes, spec 1 ☐ Yes y		n, Mexicar Specify:	i, Puerto i	cify Yes or No- Rican, etc.)		Black, \ Specify: W	White, e	etc.
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/lan	should be filed within 72 hours after death with the Maryland ind Mental Hygiene. In the Maryland sharked other than "natural", or items 23s or 28s-f show umatic event, the Maryland Exercities marked rediffied at	To Be	Henry L. Mangels								laurer		,		
E	2 sh and is m		19a. Informant's Name/Relationship (T) Beth Myers (Niece)	ype, Print)			-				Route Number Baltimo:	-			
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	permit. Pages Department of Important: If it eny injury or o		1 X Burial 2 □ Cremation 3 □ I 1 4 □ Donation 5 □ Other (Specify))	(a(e	k Lawn	Cemet	tery			-2010	Bal	timor	e,	Md.
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ο, Ω,	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (o	r as a consec	quence of):									
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Records,	w requires that been signed t should be det										1 □ Y	es 2[]No 3[] Proba	ably 4 Dunknown
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<u> </u>	hysician: this certific al director,	To Be	examiner?	Hospital: 1 ☐ In	patient 2	ER/Outpatien	t 3 🗆 DO	A Othe			ne 5 Reside	-	Other (Specify)
0 00	ding Pt h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Month)	Injury , <i>Day Year)</i>	28b. Time of Injury	M 2	8c. Injury Work	at ? ′es 2 □ l		8d. Describe ho	ow injury	y occurred		
Division of	ial or Attendii s after death. al Director: A ad in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	289. Place 0	of Injury - At h g, etc. (Specia	ome, farm, str		_	95 Z []		8f. Location (Si City or Town			or Rural	Route Number,
ā	spital or ours afte seral Dir filled in														
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medicai	29a. Certifier 1 V Certifying Phy (Check only one)	ner: On the bas and manne	is of examina	owledge, death ation and/or inv	occurred a estigation,	at the tim in my op	e, date an inion, dea	d place, a th occurre	nd due to the cand at the time, d	ause(s) ate and	and manne place, and	er as sta due to	ated. the cause(s)
	vithir To th comp	Me	29b. Signature and title of certifier	1	/	12 T		. License		00			e signed (N		
,			/ 4/ /	AWVOI					617						9, 2010
	10		30. Name and address of person who con LOPPAINE OF ORI-	AWUAH	MD. 5	430 CF	MABI	ELL	BLU	0,57	E 214,	BAL	TIMO	RE	MO 21236
	Sta Registra		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ature									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30tePerviolWhan 6900epa/th96/2010Health and Mental Hygiene 2 04568 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Charles Skirven 2010 3:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1272 Sugar Maple Drive Marriottsville Howard 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 XM 2 🗆 F Months Hours January 22,1951 59 Director 215-58-1587 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if fem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Marical Examples 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 x No Maryland Marriottsville Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1272 Sugar Maple Drive 21104 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 X Married Yes 2 K No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: If Yes, Give 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Residential and Elementary/Seconday (0-12) Commerical Real Estate Real Estate Developer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Skirven, Sr. Louise Devine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1272 Sugar Maple Drive Marriottsville, Maryland 21104 Isabelle Anderson-Skirven (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Crestlawn Memorial Gardens 2-17-2010 Marriottsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenson witzke Funeral Hounes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 10ar disease or condition Medical resulting in death) as a consequence of): **Examiner** Sequentially list conditions Examiner Use to (or as a consequence of): If any, leading to immedicause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year been signed by the should be detached Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy perform certificate 1 Yes 2 No 25. Was case referred to medical Certificate; To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of within 24 hours after death.

To the Funeral Director: After t 1 Natural work? 5 Pending 2 🗆 No Investigation Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature title of certifier

Registrar DHMH 17 Rev 7/2009

State

Little Patuxent Pkwy. Columbia MD 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11065

Edward J. Lee

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of	Maryland /		artment of F rtificate of		Mental Hy	/giene Reg. No		04569
	Physici	an	1. Decedent's Name (First, Midd						2. Date of D Month Feb. 1	Da	010 Year	3. Time of Death
1	/Medi		Mabel Je 4a. Facility Name (If not institution				4b. City. Town. o	r Location of Deat	1		. County of Deat	
1	Examir	ier	Genesis Nursin	-	/		Brook1			1	Baltimo	
5.5	Funeral Director		5. Social Security Number 219–22–3637	6. Sex 7. 1 ☐ M 2 👿 F	Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		irth Pay, Year) -1928	9. Birt Okl	hplace (State or Foreign untry) ahoma
	and w		Usual Residence of Decedent 10a, State 10b, Count	v	10c. City, To	own or Lo	cation					10d. Inside City Limits
	Maryll	ţō	MD Anne	Arundel			Glen Buri	nie				1 ☐ Yes 2∰No
	r 28e	Director	10e. Street and Number	m under			10f. Zip Code			10g. Cit	tizen of What Co	untry?
	th wit	aiD	106 Hollywood	Drive			210	060		U	nited S	tates
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23s or 28e-f ehow other treumatic event, the Medical Examinar must be codified at	by Funerai	11. Marital Status 1 Never Married 2XXMa 3 Widowed 4 Divorce	If Yes Give	es? <u>⊊</u> ∏No		Was Decedent of Hif Yes, specify Cuba 1 ☐ Yes 2 XX No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: Wh	
5-0	72 ho	Completed	15. Decede	ent's Education est grade completed)	10	6a. Dece	dent's Usual Occup	ation during most of wo	rkına	16b. K	(ind of Business/	Industry
21	within ene.	mpie	Elementary/Secondary (0·12)		or 5+)	life.	kind of work done DO NOT use retired		, All 19			
	filed w Hygier other ti	Ö	12 17. Father's Name (First, Middle	2			Homemal	Cer 18. Mother's Na	me /First Middl	e Maider	Own Ho	me
Maryland	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Me	o Be	Ernest Heintz	, Last/				Erma Sl		o, maidei	Jumamey	
ary.	should nd Men marke	To	19a. Informant's Name/Relation	nship <i>(Type, Print)</i>	1	19b. Mailir	ng Address (Street			ber, City	or Town, State, 2	Zip Code)
	1 and 2 Health a tem 27 is		Sandra S. Pens	el - Daught	er 1	.06 H	ollywood	Drive, (Glen Bur	nie,	Maryla	nd 21060
Baltimore,	permit. Pages 1 and Department of Heal Importent: If Item 2 eny injury or other ones.		20a. Method of Disposition 1 → Burial 2 □ Cremation 4 □ Donation 5 □ Other (ale		sition (Name of matory or other place ge Mem Pl		Date 22-2010		ocation - City or	Town, State Maryland
Balt	permit. Departr Importe eny inje		21. Signature of Fun, ral Service	BioRau	w							al Home at e, MD 21075
ŧ			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that caust only one cause on each	sed the death. E	Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between
	Physician /Medical Examiner	ler	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	b	as a consequent		Deme	aitn				Onset and Death
68760,	icate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequent	ce of):						
P.O. Box (The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		h 2 Fetal death nt at time of death	ath 3[Ectopic pregnancy Other (specify)	/			23d. Date of de Month	ivery Day Year
	s that ned t	by P	Part II. Other significant condit	tions contributing to deal	th but not resultin	g in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
rds	w require been sig should b	ed b	Hypertens	wia					1 🗆	Yes 2	□No 3□Pr	obably 40 Inknown
I Records,	The law re cate has be page 2 sho	Completed							24a. Wa auto per 1 ☐ Yes	opsy formed?	death?	utopsy findings available completion of cause of 2 No
of Vital	ding Physician: Th h. After this certificate funeral director, pag	Be	25. Was case referred to medic examiner?				1	26. Place of De	ath Check only	one)		
of	Physic this c	J.	1 Yes 2 No	Hospital: 1 ☐ Inp 28a. Date of		Outpatier b. Time o	IL SLI DUA		Home 5 ☐ Res		6 Other (Spe	cify)
	ding h. After fune	tion	Natural 5 ☐ Pend		Day Year)	Injury	Wor	yat rk? Yes 2 ∐No	280. Describe	now inju	ny occurred	
Division	after death. Director: After d in by the fune	Certification:	3 Suicide 6 □ Could	d not be 28e. Place of	Injury - At home , etc. (Specify)	, farm, str	eet, factory, office			(Street al own, State		ural Route Number,
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one) Certify Certify Certify Certify	ing Physician: To the bal Examinar: On the bas and manne	is of examination	dge, deat and/or in	n occurred at the till vestigation, in my o	me, date and place ppinion, death occ	e, and due to the	e cause(s e, date an	s) and manner as d place, and due	s stated. e to the cause(s)
	with To t	Σ	29b. Signature and little of certifi	ier			29c. Licens			29d. Da	ate signed (Mont	h, Day, Year)
•	1 .		·		ND			23465	-		2/17/11	3
	41		30. Name and address of person	eses MD	784	5	OAKW	ood Ro	ad G	len		MD 2106
	Sta Registi		FEB 19 2010	Denova 32. Reg	gistrar's Signature	ale	•					

DHMH 17 Rev 1/2001

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Amend 4c per MD g901 3/10/10 TT

State of Maryland / Department of Health and Mental Hygiene 20 1 for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician SIMON 03:21 AM avid 6106 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner moryland medical Baltimore CH Pennsylvania N/A University O. | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) | October 25,1946 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**X** M 2□ F Months Pennsylvania 196-36-5132 Director Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 ▼ No Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or? 10245 Glastonbury Road 21042 U.S.A. Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Realtor Residental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Simon Peter Simon Nora Hassev ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trac Patricia Simon (Wife) 10245 Glastonbury Road Ellicott City, Maryland 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Crestlawn Memorial Park 2-22-2010 Marriottsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Col 21. Signature of Funeral Service License Columbia, Maryland 21045 23a. Part 1. Enter the disease. Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) renation **Physician** としとい wal /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-trar Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy
performed?

1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1₽ Yes 2 No Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 7:00 PM 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2-16-2010 2 🗹 Accident tell on 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide city, mb Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P24459 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore almalku Greenest. 101210 22 31. Date filed (Month, Day, Year) State FEB 19 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	artment of Health and Me	ental Hygier	ne
				ertificate of Death	Reg.	No.2010 04571
П	Physici	an	1. Decedent's Name (First, Middle, Last)		 Date of Death Month I 	Day Year 3. Time of Death
-Tale bang	/Media	al	Virgie M. Salyers 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	ebruary	15 2010 08:55 PM 4c. County of Death
الا " حيد	Examin	er	Anne Arundel General	Annapolis		Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign
	Director		217-46-2893 1□M 2☐F 94 Yrs.		Nov. 11 1	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	ocation		10d. Inside City Limits
	Mary Fresh	tor	Maryland Anne Arundel	Pasadena		1 ☐Yes 2 ☒No
	or 28g	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	ath wi		7787 East Shore Road	21122		USA
	er dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, it as Medical Evarther must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White
S S	72 hou natura fical E	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working	16b.	Kind of Business/Industry
7	ithin ne.	mple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	,	
2	iled w Hygie ther ti	Co	5 17. Father's Name (First, Middle, Last)	Homemaker 18. Mother's Name (First Middle Maid	Household
a	d be f ental ked o c eve	To Be	Daniel B. Emory	Virgina	11121	ilev
Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	F		ing Address (Street and Number or Rural		
2	1.2 g g		Richard Salyers (son) 36 S	ierra Lane, Arnold,	MD 2101:	2
sattimore,	jes 1 au t of Hea lfitem or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	osition (Name of Pairmatory or other place)	te 20c.	Location - City or Town, State
	t. Pag rtmen rtant: njury		4□Donation 5□Other (Specify) Glen Hav	en Cemetery 201		en Burnie, Maryland
ga	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Funeral Service Lifensee	2. Name and Address of Facility S 3111 Mountain Roa	_	Funeral Home, P.A.
			23a. Part i. Enter the disease, or complication; that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between
-	Physician	i W	shock, or heart failure. List only one cadse of each line. Immediate Cause (Final disease or condition	Anryltonia		Interval Between Onset and Death
	/Medical		resulting in death) a. Due to (or as a consequence of):	THE TOURS		
	Examiner	ڀ	Sequentially list conditions, b.			
_	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
)	ificate be executed g physician and is the burial-transit	Exa	that initiated events c c Due to (or as a consequence of):			
00/9	ate be nysicia	dical	d			
20	ertifica ling ph e as th	Med	IF FEMALE:			
Ž D D	attend for use	ian/	23b. Was decedent pregnant in the past 12 months?	☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
j	the de	Physician/Me	1	Other (specify)		
T	that ned b		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
cords	quires en sig ruld be	ed by	failure to thrue.		1 □ Yes	2 No 3 Probably 4 Unknown
ວ	law re as be 2 sho	Completed			24a. Was an	24b. Were autopsy findings available
<u> </u>	The cate h	Som			autopsy performed 1 Yes 2	
N 150	fclan; Sertific ector,	Be (25. Was case referred to medical examiner?	26. Place of Death (
5	Phys rthis ral dir	P.	1 ☐ Yes 2 ☐ Mospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time o		e 5 ☐ Residence	6 ☐ Other (Specify)
5	th. : Afte	Certification: To	1√Matural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Work? M 1 □ Yes 2 □ No	d. Describe flow in	jury occurred
2	Atter ector by the	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)			and Number or Rural Route Number,
5	ital or rs afte ral Dir led in	Sert	Full formed building, etc. (Specify)		City or Town, Sta	ate)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within E4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, an nvestigation, in my opinion, death occurred	nd due to the cause d at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	Vithin Volume Comp	ž	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
•			70 Name and address of agree with a small dark of a re-	1)57028		-116/10'
	S		30. Name and address of person who completed cause of death (Item 23a) (Type, A Chara 600 Ricligely)	Are Ste 231	Anap	de mo2140/
	Stat Registra		FEB 19 2010 Sever 5. Again		/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2010 11:20 AM enise /Medical ricia 4a. Facility Name (If not institution, give street and number) Town, or Location of Death **Examiner** 4c. County of Death HOS-PITO1 ITMOV If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Min. Days -80-1 □ M 2 🖫 F Hours 313-80-1831 Usual Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if than "natural", or items 23a or 28a-f shore the Medical Even included by natified at 1 🗹 Yes 2 🗌 No Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 12. Was Decedent Eve Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No permit. Pages 1 and 2 should be filed within 72 hours afti.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or i any injury or other traumatic event. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Blac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a_Informant's ame/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name cametery, crematory or other 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23-2010 Baltimore MD 21. Signature of Funeral Service Licensee and Address of Facility Vaushac. Greene Fineral Services an Kundallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death etween t and Death Immediate Cause (Final **Physician** disease or condition resulting in death) M /Medical Due to (or as a consequence of): Bilateral Pneumonia Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner ue to (oi as a consequence oi): reno Va45 and burial-trai requires that the death certificate be exec-Due to (or as a consequence of): attending physician letastatic Breast Physician/Medical 500 the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 ☐ Other (specify) 1∐Yes 2. ⊠No signed by the o 9 Unknown 9 Unknown · by · Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 Unknown 1 🗌 Yes 2 000 Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has director, page 2: certificate 2 🗆 No Division of Vital 1 ☐ Yes 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗀 🖔 🖰 1 Dipatient 2 ER/Outpatient 3 DOA Medical Certification: To this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 To the I 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 16,2016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ave State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month 6432 AM Schools Phillip ZOLU Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Raltmore Maryland Medical System 35 Bultmore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 212.56.4319 **X**M 2 □ F MD Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Baltimore Windsor MU 1 Yes 2 No MD 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral Road Woods . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Depot TEAM 2 years REIGHT 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clayton Schoolsisr. arri 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HT Barkley Woods Road Windsor Mill, MO21244 Patricia Schools 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State -22-2010 Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Vangen C. Greene Funeral Services 8728 Liberty Road Randall Jown MD 21133 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Anerrysm with Dissection Descending Sequentially list conditions, Examine cause (Disease or linjury the attending physician and the for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Arch Aneung Aurtic that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown Kidney Chronic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy berformed: 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2/12/10 19924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mayland Medical System, 225. Greene St. COMAZ 31. Date filed (Month, Day, Year) **FEB 19 201**0 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G901, 3/2/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 17, Month **Physician** I. Stollenmaier 2 P Joseph February 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens Parkville Baltimore County If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
7–16–1924 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**XM 2□ F Director 85 Maryland Usual Residence of Decedent with the Maryland 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Exeminer must be notified at Director Maryland Baltimore Parkville 1 ☐ Yes 2 ☑ 💥 🗸 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8832 Walther Boulevard #113 South 21234 USA Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1**XX**es 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 🗶 No Specify: 3 Widowed 4 Divorced white "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withi Health and Mental Hygiene. 12 Electronic Engineer US Government 7 is marked other traumatic event, Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irvin Stollenmaier Lula Bonhoff ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trat once. Dorothy V. Stollenmaier 226 Garden Way Westminster, Maryland Dulaney Valley Memorial Gran 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Timonium, Maryland 5 ☐ Other (Spec 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, Maryland 21211 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a Part I. Enter the disease, or compil ati-shock, or heart failure. List only on co-immediate Cause (Fina disease or condition resulting in death) Approximate Interval Between Onset and beath Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was unautopsy performed. 2 No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manuer of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ö e Hospital on 24 hours af Euneral D PRACTITIONER 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifler (Check only one) and manner stated. To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTHER BLUD 31. Date filed (Month, Day, Year) State 19 2010 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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_			Registrar		Cer	tificate of D	eath		R	leg. No.		0 10 10
	Physicia	ın/	Decedent's Name (First, Middle, Last)						2. Date of Deal 2^{Month}		Year	3. Time of Death
	Medic		Shirley Ann 4a. Facility Name (if not institution, give street	Smith		4b. City, Town, or	l in a literature of	ED with	<u> 2 - 15</u>			10:10 A M
	Examin	er	Gilchrist Hospice	and number)		Tows		Deam		4c. County o		County
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year _	If Under 2		8. Date of Birth		g. Birthp	lace (State or Foreign
	Director		217-68-3015 1 □ M	¾√√√ 71	Yrs.	Months Days	Hours	Min.	(Month, Day, 2-12-19	939	Count Mary	Iand
	d ow t		Usual Residence of Decedent 10a. State 10b. County	40-107-1								
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	23a st be	eral	804 Berry Street				2121	11		rog. Oilizerror W	US	
	tems er mu	Funeral	11. Marital Status 12. V	Vas Decedent Ever in U.S.	13. V	las Decedent of His	spanic Origi	in? (Spec	ify Yes or No-	14. Race		
9	filed within 72 hours after death with the Maryland al Hygiene. I other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1	rmed Forces? ☐ Yes ※ No Yes, Give	- 1	Yes, specify Cubar Yes 2 No		Puerto H	ican, etc.)		, White, e	tc.
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5	72 h in "ng Medic	nple	15. Decedent's Educati (Specify only highest grade co	mpleted)	(Give k	ent's Usual Occupa ind of work done do NOT use retired)		of workin	g	16b. Kind of Bus	siness Ind	ustry
212	within jiene. er the the I		Elementary/Seconday (0-12) C	ollege (1-4 or 5+)		Homemake	er			I	n ow	n Home
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Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	2	Charles Harry Hen	ze			Edi	ith M	May Lutn	nan		
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oʻ	and 2. Health em 27 ther tr		Cynthia Miciche D 20a. Method of Disposition	aughter		Willow C	Dak Ro					21234
פֿר	Page 1 ament of hand of hand: If ite		1X Burial 2 Cremation 3 Remo	oval from State cem	etery, crem	sition (Name of atory or other place				20c. Location - 0	-	
Baltimore,	permit. Page 1 and 3 Department of Heall Important: If item 2 any injury or other		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Secure Livensee	\(\text{/res}		n Memoria Name and Address			20/10	Marriot	tsv1	IIe, MD
Ba	permit. Departr Imports any inji		21. Signature in different see	1 Partie	Bu	rgee-Hens 31 Falls	s or Facility S s -Sei	t <u>z</u> Ę	uneral	Home, I	nç.	
			23a Part 1-Enter the disease, or complication	ons that caused the death. D	o not ente	r the mode of dying	ROAD , such as c	ardiac or	respiratory arre	. Marryla st,		1 21 1 Approximate
- 1	hysician/		shock, or heart failure List only one cau Immediate Cause (Final disease or condition	A 1	1 A Av	A LA (A MI	1				- (Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequence	ce of):	CINOUSSE	7				-	MONTHS
	LAdillilei	ř	Sequentially list conditions, b. —									
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χ ×	h cert tendir r use	an/I	23b. Was decedent pregnant 23c. If	yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal de		Ectopic pregnancy	,			23d. Date	of delive	ry
X R R	death the atte	Physician/M	1 Ves 2 🗷 No 4	☐ Pregnant at time of deat ☐ Unknown	h 5 🗆	Other (specify)				Mont	th I	Day Year
Ö.	ad by detacl	'Ph	Part II. Other significant conditions contribu	ting to death but not resulting	ng in the ur	derlying cause give	en in Part I.		23e. Did tob	acco use contrib	ute to the	e cause of death?
လှ ၂.	v requires that the death certific been signed by the attending should be detached for use as	d by	DIABETES						1 □ Y€			ably 4 Unknown
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Division of	lor A after Direc	Çe	4 Homicide determined	 e. Place of Injury - At home, building, etc. (Specify) 	, farm, stre	et, factory, office		2	Bf. Location (Str City or Town,	eet and Number State)	or Rural I	Route Number,
_	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by it completed filled in by the funeral director, page 2 should be detacht.	Medical	29a. Certifier 1 Certifying Physician:	To the best of my knowledg	e, death o	ocured at the time,	date and pla	ace, and	due to the caus	e(s) and manner	as stated	
	he Hc iin 24 he Fu iplete	Med	(Check 2 ☐ Medical Examiner: O only one) 3 ☐ Certifying Nurse Practice	n the basis of examination an	d/or investi	ation, in my opinior	n, death occi	urred at the	ne time, date and	d place, and due to	o the caus	se(s) and manner stated.
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	10		30. Name and address of person who comple DANIEUE DOBERMAN, M.	ted cause of death (Item 23)	a) (Type, Pr	int) 3 ST, 8U	UTE 4	701		MORE, N	10 2	1204
	Stat Registra		DANIEUE DOBERMAN I MU 31. Date filed (Month, Day, Year) FEB 19 2010	32. Registrar's Signature	park							
			LEN TA FOIA	- "								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Scorzato Mary Elizabeth 20/ /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** seda 0 If Under 24 Hrs. 7. Age (In yes. last birthdav. 8. Date of Birth (Month, Day, Year) Social Security Numbe **Funeral** Min. Months Days Hours 1 - M 2/2015 Maryland Director 215-20-8296 82 12-16-1927 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shore Examiner must be notified at 1 ☐ Yes ¾ No Director Essex Maryland Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with trent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or: ury or other traumatic event, the Medical Experiment must be not or other traumatic event, the Medical Experiment must be not or other traumatic event. 21221 8620 Kelso Drive Apt. 102 A USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes ¾∏No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 🏋 No Specify Specify white 3€Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife In own home 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Norwood Starner Effie Blanche Fox 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James Smith Son 10 Barletta Court Rosedale, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o once. Maryland Veteran Cemetery 3/2/10 Owings Mills, Maryland 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc 21. Signature of Funeral Service 3631 Falls Road Baltimore, 21211 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one causeion each line. 2 (a. Part 1. Enter the diseas shock or heart failu e Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death sebsis **Physician** /Medical Due to (or as a consequence of): Examiner IMMunoSu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2 No certificate has been signed by the irrector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

P.O. Box 68760, Division of Vital Records, ours after death.

eral Director: After this certific filled in by the funeral director, 24 hours a within 24 hou

To the Fune

completely fil the

29b. Signature and title of certifier

9

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year) 16 2010

MD

31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Francis Stricker ebruary 2010 2:18 М Α Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Country) Maryland If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday (Month, Day, Year) Oct 2, 1918 Min. 1 X M 2 | F Director 217-09-5650 91 Usual Residence of Decedent shov 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 28a-f MD Baltimore Towson 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1 Smeton Place #1003 21204 USA and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. white 1 Never Married 2 Married ō Ď Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Yes Give "natural", Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) vice president transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John Michael Stricker Mary Virginia Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Smeton Place #1003; Towson, Maryland 21204 f Health a item 27 i Gladys Stricker/wife other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 permit. Page 1 Department of Important; If it any Injury or o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 N Donation 5 Other (Specify) State Anatomy Board; 655 W. Baltimore Street Director Baltimore. Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician, years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death
Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year detached 1 ☐ Yes 2 ☐ Unknown q certificate has been signed by rector, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 🗆 Yes 2 🗆 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 (Other (Specify) 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Deat 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Matural (Month, Day, Year, iniury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatur 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

9 2010

6701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

29c. License number

N- Charles

2010

(ason M)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2010 James Earl Stinchcomb 11:15 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 8. Date of Birth (Month, Day, Year) Dec. 15, 1925 Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Hours Country) Director 212-20-3964 Dec 84 Usual Residence of Decedent "natural", or items 23a or 28a-f shovedical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Howard MD Elkridge 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6544 Baja Way 21075 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc. 1 Never Married 2 Married Completed by 1 X Yes 2 No 1944-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 ☐ Divorced 1945 White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 10 <u>Director of Engineering</u> <u> Hospital</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James L. Stinchcomb Evelyn F. Harmis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon L. Long / Daughter 6839 Littlewood Ct., Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet. Cem! 2/25/2010 | Crownsville, MD . M01411 21. Signature Sery 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. e Licensee and 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) Medical Due to (or as a con equence of Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown 24a. Was an . Were autopsy findings available prior to completion of cause of autopsy perforn death? certificate Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this To the Funeral Director: After th completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Tyes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nume Prentiemen To the best of my knowledge, deeth potum at the time 29b. Signature and title of certifie FEBRUARY 18, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MS 21204 DANIEUL DOBERMANIMS 670 N CHARLES ST. 8WITE 4105 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SIEGEL Lillian Τ. 5:02 P.M February 13, 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F 85 Hours March ^DB, ^{Yea} 1924 New York Director 124-14-9985 Usual Residence of Decedent 10c. City Sill ver Spring Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant; if item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at State Md . Montgomery 10d. Inside City Limits Director 1 🗌 Yes 2 🖔 No 10e. Street and Number 10f. Zip Code 20902 10g. Citizen of What Country? U.S.A. Bluff Terrace Funeral 111 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Race - American Indian Armed Force 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education 5+ Teacher/ Counselor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ESTAEY DECKEY Tessenholtz ည Harry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9217 Midwood Rd., Silver Spring, Md. 20910 Ruth Alpert / daughter 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Important; If it any injury or o Mt. Lebanon Cemetery Feb. 17,2010 Adelphi, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home . Signature of Funeral Service License 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final C-Diff Colitis Severe Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Bacteremia and Funguria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence or): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been sinned by the attendance in the continuation of the continuatio the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ XNo Month Day Year 5 Other (specify) 9 Unknown within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: ၉ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioners to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0069<u>838</u> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 V 1500 Forest Glen Rd., Silver Spring, Md 20910 Sangeetha Ranganath, MD 31. Date filed (Montp Ex Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Harry Earl Taylor III 2010 9:00 P M February 4 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/13/1950 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 X M 2 □ F 60 Director Washington, D.C. 218-58-2176 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, The "Medical Expressions", and by notified at Director 1 ☐ Yes 2 ☑ No MD St. Mary's Leonardtown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 43217 Belvidere Farm Road 20650 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify ģ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) None Clerk Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev Harry Taylor, Jr. Yvonne Snyder 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Taylor, Jr. / Father 43217 Belvidere Farm Rd , Leonardtown, MD 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/17/2010 | Hanover, Maryland 4 ☑ Donation 5 ☐ Other (Specify) Analony Gifts Registry 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service bicense 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Cardiovascular **Physician** AR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Justo for as a consequence of) Examine Due to (or as a consequence of): attending physician a for use as the burlal-Box 68760 requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate Vital 2 No 1 □Yes 20 Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient ER/Outpatient 3 ☐ DOA Certification: To ō 27. Magner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 □Yes 2 □ No of the state of th 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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31. Date filed (Month, Day, Year) FEB 19

BABATUMDE

30. Name and address of person wno completed cause of death (Item 23a) (Type, Print)

OROGBEM1

Registrar's Signatur

Box

0006898

524 Leonardton

200

20650

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ ireniece 810 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 09/06/1953 1 □ M 2 🔀 F Months Days Hours Min Director 215-62-3426 56 Maryland Usual Residence of Decedent 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director 1 Yes 2 X No MD Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event; the Medical Examiner must be any injury or other traumatic event; the Medical Examiner must be once. Funeral 1209-C Old Mayo Road 21037 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Data Processing Computer Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Francis Huffer Betty T.ee Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Jacob Tippett / Son 12708 Cherry Wood Lane, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 02/19/2010 Hanover, Maryland 21. Signature Funeral Serice Lio 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final KeMIO Physician/ disease or condition years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No Completed 3 Probably 4 Unknown cate has been signated bage 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? 2X No 1. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1.X Natural 2 🖵 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Xertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practices: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year,

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year)

Bestgate Rd Sule 300 Amapli MD 2140

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 04582 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Feb Physician/ Year >arah 18:38 PM wrner 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Bayview Medical Center Baltimore Hopkins Age (In yrs. last birthday) If Under 1 Year If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** May 17, 1919 Months Days Min. Hours Georgia Director 90 216-40-1920 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 ☐ Yes 2 🛣 No Middle River MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 United States 9444 Windpine Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2X No Specify: Specify: Completed 3 🕅 Widowed 4 🗆 Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 8 Years Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alma C. Reville James S. Inglette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9444 Windpine Road Middle River, Maryland 21220 Mrs. Brenda Gill (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 18°, 2010 Feb. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Elkridge, Maryland Meadowridge Mem. Park Cem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 5 Other (specify) Month Year ☐ Yes ∠ ... ☐ Unknown signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No this certificate has ral director, page 2: 1 Yes After this certific funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Man of Death 28c. Injury at work? 1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending n 24 hours aren ___ he Funeral Director: A __lefed filled in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mysician Intern s of person who completed cause of death (Item 23a) (Type, Print) and a Baltimore, MD

DHMH 17 Rev 7/2009

State Registrar 32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23a&23PII Per Phy G9002/19/2010 JH
Amend 20a-C, 22, Per Fh G9013.31 Feath and Mental Hygiene

Certificate of Death

Reg. No. 2 | | | 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Seasons Hospice at Northwest Hospital Randallstown <u>Baltimore</u> 8. Date of Birth (Month, Day, Year) June 21, 1961 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours Min. 1 ☑ M 2 ☐ F June Washington DC Director 578-96-3738 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show If than "natural", or Items 23a or 28a-f show the Wedical Examination ust by notified at MD Randallstown Baltimore 1 ☐ Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or thems 27% any injury or other traumatic event. If the 25% once. 4254 Cayuba Road 21133 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify: black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CVS cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Russell Dorothy Thorpe ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7513 Mandan Rd; Apt 203; Greenbelt, Maryland 20770 Deidra Bell/sister 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Cedar Hill Cemetery 1 ☐ Rurial 2 ☐ Cremation 4 ☐ Donation 5 10 Other (3 Removal from State 2/23/2010 Suitland, MD W.H. Bacon P.H. 3447, 14th St., N.W. 21. Signature pruneral S vice Licens Director Baltimore, Maryland 21201 Washington, D.C. 20010 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Human Immunodefiency Disease **Physician** disease or condition resulting in death) /Medical to (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examine The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery ned by the atter detached for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) l ⊈Yes 2 ☐ No 9 Unknown signed by t sulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Pneumonia page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Natural Accident 5 Pending 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after death. To the Funeral Director: 1 □Yes 2 □ No investigation the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of sertifier State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** William S. Thornton P 02-14-2010 0119 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 607 Westbury Rd Fallston Harford If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, 01-13-1919 9. Birthplace (State or Foreign Country)

MI) **Funeral** Months 218-05-5683 91 **Director** Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Examinar cust be notified at Director MD Harford 1 Yes 2 No Fallston 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 607 Westbury Rd 21047 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medical Evarranconce. Black, White, etc. 1 MYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔯 No Specify <u>À</u> Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Howard Thornton Mary Jenecek ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Domenica T. Thornton (wife) 607 Westbury Rd Fallston, MD 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Highview Mem. Gar. 4 ☐ Donation 5 ☐ Other (Specify) 02-19-2010 Fallston, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Schimunek Funeral Home of BelAir ail Rd BelAir, MD 21014 Inc 610 W. MacPhail Rd BelAir, MD or complications that caused the death. Do not en er the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use to you as a consequence of) Examiner the death certificate be executed burial-transit and f. necemani Due to (or as a consequence of) signed by the attending physician I be detached for use as the buria Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ☐Yes 2☐No 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been significate has been significated by page 2 should by 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate 1 ☐Yes / 2 ☐No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case refer -d to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Sesidence 6 Other (Specify) 2 No ၉ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA hours after death.

neral Director: After this y filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

29b. Signature and title of certifier

30. Name and address of person

5

(Month Day, Year) 192010

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760,

of Vital Records,

Division

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sui

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma		artment of Heal [.] rtificate of Deat		tai Hygiei Reg.	0010	01505				
		H	Decedent's Name (First, Middle, Last	st)		timodio or Bodi	2. [ate of Death		3. Time of Death				
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	Examin	er	4a. Facility Name (if not institution, give		-1 0-1-	4b. City, Town, or Locat	tion of Death n Burnie		4c. County of Death					
	Funeval		Baltimore Washin 5. Social Security Number 6. S	ate of Birth	Anne Arundel 9. Birthplace (State or Foreign									
	Funeral Director			☐ M 2 😡 F	(In yrs. last birthday) 97 Yrs.	If Under 1 Year If Under 1 Months Days Hou			Day Year) 1912 Country) MD					
	and show	tor	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits				
	Maryl 28a-f otifiec	Funeral Director	Maryland Anne A	rundel		Glen	Burnie		5-4	1 🗌 Yes 2 🔀 No				
	h the	al D	10e. Street and Number			10f, Zip Code		10g.	Citizen of What Cou	untry?				
	ath wii ms 2 musi	ner	992 7th Street	12. Was Decedent E	vor in II C 12	Was Decedent of Hispanio	1060	(ac ar Na	USA					
Maryland 21215-0036	is filed within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 I If Yes, Give Year or Dates.	No	was beceden of hispanic If Yes, specify Cuban, Men 1 ☐ Yes 2 ☐XNo Spe	xican, Puerto Rican	es or No- i, etc.)	14. Race - Ameri Black, White Specify: Wh					
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ylar	ild be filk Mental narked c	욘	William Cro	sby			Adeline	Turr	ner					
Nar	12 should be fill alth and Mental 27 is marked or traumatic ever		19a. Informant's Name/Relationship (7)	ype, Print)		ng Address (Street and Nu				Code)				
e, 1	1 and 2 of Health item 2 other t		Beverly DeBold 20a. Method of Disposition	(daughte	r) 992 20b. Place of Dispo	7th Street,	Data	200	21060 :. Location - City or 1	Fown State				
mor	Page 1 nent of ant: If it ary or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cemetery, crei	matory or other place) en Cemetery	Feb. 2010	18	•	, Maryland				
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once.		21. Signature of Funeral Service Lidens		1 -	2. Name and Address of F	acility Stal	lings E	Funeral Ho	ome, P.A.				
			23a. Part 1. Enter the disease, or com	plications that caused	the death. Do not ent				1a, MD 211	Approximate				
E	Physician		shock, or heart failure. List only one dause on each line. Immediate Cause (Final disease or condition Interval Bety Onset and D											
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Box 68	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as it	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli	very Day Year				
s, P.O.	requires that the de been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death bu	ıt not resulting in the ι	underlying cause given in I	Part I.		co use contribute to	the cause of death?				
ord	requir been should	lete						24a. Was an	/ -	opsy findings available				
Division of Vital Records,	: The law icate has r, page 2 s	Completed						autopsy performed 1 Yes 2	? death?	ompletion of cause of				
/ita	/siciar s certii directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	nt 2 KER/Outpatie	_ Other	Death (Check only		6 ☐ Other (Specif	5.1				
of \	ing Phy vfter this uneral c		27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of injur (Month, Day,	28b. Time of	f 28c. Injury at work?	28d. [Describe how in		<i>y)</i>				
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Divi	tal or A		4 ☐ Homicide determined	building, etc.		,,,		City or Town, Sta		ar riodic rearridor,				
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical	(Check 2 Medical Exam	iner: On the basis of ex	amination and/or inves	occured at the time, date a stigation, in my opinion, dea death occurred at the time,	th occurred at the ti	me, date and pla	ace, and due to the ca	ause(s) and manner stated.				
~	To the with To the company of the co		29b. Signature and title of ceptifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) SRID HAR. ATIVA 7310 Referred Hyphway # 800; Glen Byynie HD 2106) 31. Date filed (Month, Day, Year) 52. Registrar's Signature											
-	2		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type, F	Print) yoh way	# 800 ;	Glev		HD 2106)				
	Stat Registra	te ar	31. Date filed (Month, Day, Year) FEB 1 9 201 (62. Registrar	's Signature	p)								

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#12,15-18,20a-c,22perFH,6902,4715,2010,WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 HABI THORNTO Medical 4a) Facility Name (Mnot institution, one litrest and Number) SPITA **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 112 PRIN(GLEN R NE 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Min. Months Days Hours Country) 6-64-180 **Director** Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside Çity Limits Director 1 M Yes 2 No MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 209 ORCHARD 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ģ ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed NHITE Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired)
Food Service Elementary/Seconday (0-12) College (1-4 or 5+) Fed Government 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter E. Thornton Mary A. Komiakoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BD EN MR CROSS FOREST HOSTN Important: If Iten any injury or othe once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specify) 🗓 🖺 State rk. Crematory: 2-2/-10

Name and oddres of Facility Curry & Tellington Funeral Home
304. Georgia Ave. Ave. Tellington Funeral Home
altimore Maryland 71200

The mode of dving such as san't permit. Page Department 4 □ Donation

Signature of Funda Service License de l'Anal de l'A Riverdale Pk. Crematory , Director 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fair. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MISTLESS ELECTRICIAL ACTIVITY disease or condition resulting in death) **Medical** Due to (or as a consequence of): Examiner ARDIA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): HOCK within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENGI 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: 5 \square Pending work? 1 ☐ Yes 2 ☐ No 1 Natural Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KKAJ1 as FOREST 31. Date filed (Month, Day, Year) FEB 1 9 2010 82. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) **Physician** February 2010 5:32 P Aaron Tann /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince Georges Hospital Cheverly Prince Georges 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country UNK 7. Age (In vrs. last birthday) **Funeral** Min 1⊠ M 2□ F Months Days Hours 578-78-9258 Oct 6, Director Usual Residence of Decedent the Maryland unk 10d. Inside City Limits 10h County 10a State 10c. City, Town or Location 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at DC 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. USA 20032 1310 Southern Ave SE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married Specify: black altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced "natural" Completed other than "natu 16a. Decedent's Usual OccupationUNK 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be မှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 3001 Hospital Dr; Cheverly, Maryland 20785 Prince Georges Hospital Item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In State 21. Signature Konald evice icensee Konald Wade 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Director Baltimore, Maryland 21201 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or condition resulting in death) **Physician** Fatalary ythmus. Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed g physician and is the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ great ensum 1 ☐ Yes 2 ☐ No 3 ☐ Probably 1 ☐ Unknown has been si e 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate ha 1 ☐ Yes 2 NO 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 ☐ Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No neral Director: A investigation 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after 4 Homicide

State Registrar

within 24 hours a

To the Funeral C

completely filled

Medical

29a. Certifier

(Check only one)

29b. Signature and title of

Dr. Terri

31. Date filed (Month, Day, Year)

FEB 1 9 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

32. Registrar's Signature

Hosp.

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:24PM 20 Medical City, Town, or Location of Death Examiner County of Death 8. Date of Birth Funeral 9. Birthplace (State or Foreign 050-24-5989 1 M 2 X 88 11-10-192 Country) PA Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director 10d. Inside City Limits MD Anne Arundel Severn 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7902 Tressel Ct. 21144 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give "natural" 3 Widowed 4 □ Divorced Page 1 and 2 should be filed within 72 hours and the Haalth and Mental Hygiene. ant: If item 27 is marked other than "natural Year or Dates Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Self-employed 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Pauline Zarkowski Andrew Bartush Baltimore, Mary 19a. Informant's Name/Relationship (Type, Print)
Maria P. Nowack / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7902 Tressel Court, Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of St. Peter and Paul Cem. 02/27/2010 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Avoca, PA 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Rendon-Bailey Funeral Wla 2818 E. Baltimore St., Baltimore, MD 21224 M01452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final nset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence Exami within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 morths?
1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 20 NO 2 2 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 힏 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death ancurred at the films date and place, and due to the cause(s) are manner as stated. (Check only on 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

on who completed cause of death (Item 23a) (Type, Print)

DDD14147

Dr Suite 305 Gk

10-00486
Martnell Walton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Martnell Walton	1- For State	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2010 0458									
Physician/ Medical Examine		First, Middle,Last)	= 11 /1/	A / To	5 N		2. Date of Deat Month January 1	h	3. Time of Death 1635 hrs		
	4a. Facility Name (if no 635 S. Curley	ot institution, give street a	nd number)		o. City, Town, or Lo Baltimore	ocation of Death		4c. County of	Death		
Funeral Director	5. Social Security Num 215-08-1	6. Sex	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min	_		9. Birthplace (State or Foreign Country)		
d how any	ma	ecedent b. County		Town or Location	n				10d. Inside City Limits 1 Ves 2 No		
ath with the Maryland items 23a or 28a-f show any sat be notified at once.	10e. Street and Number			77.0,	10f. Zip Code	· 14	10	Og. Citizen of Wha	at Country?		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Faut: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married	2 Married Arm	s Decedent Ever in U.S ned Forces? Yes 2 No	If Ye	Decedent of Hispa s, specify Cuban, I	anic Origin? (Sp Mexican, Puerto		14. Race - White,	American Indian, Black, etc.		
5-0036 ed within 72 hours after alygiene. other than "natural", the Medical Examiner Completed by 1	3 Widowed	4 Divorced If Yes, Gior Dates: cation (Specify only highes dary (0-12)		16a. Decedent'	Yes 2 No s Usual Occupation st of working life. D	s <i>pecify:</i> n (Give kind of v OO NOT use reti	vork done red)	Specify: 16b. Kind of Busi	WHITE iness/Industry		
21215-0036 Juld be filed within 72 hour Mental Hygiene. marked other than "matu e event, the Medical Exam To Be Completed	17. Father's Name (Fir			Co	00K	.Mother's Name	(First, Middle, N	CATON (aiden Surname)	STATION		
ore, MD 21215-00: ss I and 2 should be filed with of Health and Mental Hygiene If Item 27 is marked other t ther traumatic event, the Mea	19a. Informant's Name	e/Relationship (Type, Print	/ ,	19b. Mailing		,	Rural Route Num	ber, City or Town,	State, Zip Code)		
Baltimore, MD oemit. Pages I and 2 sho oemit. Pages I and 2 sho Oeparment of Health and Important: If tiem 27 is njury or other traumati	20a. Method of Dispos	sition	val from State cre	ace of Disposit ematory or othe			Date Date	20c. Location - C	City or Town, State		
Baltime permit. Pag Department Important: injury or ot	4 Donation 5 21 Disprature of Funer	Other Specify:	1. N	22. Na 22. Na	TOF JES me and Address o	Facility	22-10	BALTE	BALT 2126 4		
Physician /Medical Examiner			azolam and	methad				St, shock, or hear	t Approximate Interval Between Onset and Death		
ner	Sequentially list condit if any, leading to imme	tions, b	r as a consequence of): r as a consequence of):								
uted nd ransit Examine	cause. Enter Underlyi (Disease or injury that events resulting in dea	initiated ^{c.}	r as a consequence of):								
60, ate be executed hysician and e burial - transit	IF FEMALE:	AMEND	23a,PII, 2	27,28a-	f,permE,	g901 3	.3.10 T	23d. Date of de	elivery		
Division of Vital Records, P.O. Box 6876(the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending phys npletely filled in by the funeral director, page 2 should be detached for use as the b dical Certification: To Be Completed by Physician/Me	23b. Was decedent pre past 12 months? 1 Yes 2 No	egnant in the	ive birth Pregnant at time of death Unknown	2 Feta	I death 3	Ectopic pregna	ncy	Month	Day Year		
, P.O. E res that the signed by the detached d by Ph	Part II. Other significa		ing to death but not res	ulting in the un-	derlying cause give	en in Part I.			ute to the cause of death? Probably 4 Unknown		
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death. Tal Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P.							24a. Was a autops perform	prid med? de:	ere autopsy findings available or to completion of cause of ath? Yes 2 No		
/ital F sician: is certifi lirector,	25. Was case referred examiner?	Hospital: 4	Inpatient 2 E	R/Outpatient		Death (Check of		Residence 6	Other: Scene		
ion of Vitending Physicath. For: After this the funeral direction: To	27. Manner of Death 1 Natural 5	Pending TI	Date of Injury 2 Month, Day,Year)	8b. Time of Inju	ury 28c. Injury a			ow injury occurred			
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune-ledical Certification:	4 Homicide	X Could not be 28e.	Place of Injury - At home	ne, farm, street,	factory, office buil-		28f. Location (S or Town, St Baltimo:	ate)635 S .	or Rural Route Number, City Curley St		
To the Hospital within 24 hours To the Funeral completely filled		rtifying Physician: To the edical Examiner: On the ba									
To with To con	29b. Signature and title		~		29c. License n			29d. Date signed January 18,	(Month, Day, Year) 2010		
		of person who completed Assistant Medical E		•	Baltimore, MI	D 21201		-			
State Registrar	31. Date filed (Month, D	Day, Year) 3:	2. Registrar's Signature	har	. 1						

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per th 2901 3-15-10 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Douglas Phillip. Walters 10:05P Feb. 13 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Co. 8043 Baltimore Street Baltimore Co. If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral ™**M 2□ F Yrs. Director June 12,1947 Maryland 218-54-4052 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No MD Baltimore Baltimore Co. Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21224 United States or items 23a 8043 Baltimore Street Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ☐ Yes ZXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: ģ 3 Widowed 4 Divorced White "natural", Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry injury or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. n and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Years <u>Delivery Driver</u> Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stanley Walters, Sr. Margaret ပ 19a. Informant's Name/Relationship (Type. Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau 8043 Baltimore Street Baltimore, Maryland 21224 Mrs. Margaret Ann Walters 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition txxBurial 2 ☐ Cremation 3 ☐ Removal from State 26 2/17/2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Oak Lawn Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Kint. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 15 Hrterlosclerotic andlovascular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conseductice off Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): attending physician for use as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2 No certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

SPM

02/13/2010

as Wa

GHG

State Registrar

29b. Signature and title of

30. Name and address of person

31. Date filed (Month, Day, Year)



who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

			ndelible Ink. E artment of Heal		-	_	е.			
For State Registrar	Otate of W		rtificate of Deat		aı myglel Reg.	201	0 0459			
1. Decedent's Name (First, Middle,	Last)			2. Da	ate of Death	to the Car I	3. Time of Death			
	Antonet	ta Rocco	Cecelia We	CT .	onth Q	Day Year	0.2/ 04			
4a. Facility Name (if not institution,	,		4b. City, Town, or Locat	tion of Death		4c. County of De	eath			
GOOD SAMARIT	AN HOSPIT	AL	BALTIMO	ORE	_	N/A				
	4 1 14 0 17 5	e (In yrs. last birthday)	If Under 1 Year If Un Months Days Hou		ate of Birth Ionth, Day, Yea	9. E	Birthplace (State or Foreign Country)			
202-18-0777	9	7 Yrs.	Worting Baye Fried	Au	1 0		ryland			
Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	postion				1.01.1.1.00.11.0			
,	Baltimore	Toc. Oity, lowit of Ed	cation	T.d. com care			10d. Inside City Limits			
10e. Street and Number			Location in	Edgemere			1 🗆 Yes 2 🖾 No			
	. + D1		10f. Zip Code 2121	Q		Citizen of What (
8210 North Po						III LECG DE				
11. Marital Status	12. Was Decedent I Armed Forces?		Was Decedent of Hispanio If Yes, specify Cuban, Mex	c Origin? (Specify Ye kican, Puerto Rican,	s or No- etc.)	14. Race - An Black, Wh	nerican Indian, lite, etc.			
1 ☐ Never Married 2 ☐ Marri 3 🕅 Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2 🌠 No Spe	ecify:		Specify:				
15. Deceden	Year or Dates.	100 D	donto Havel O			1	White			
(Specify only highes	t grade completed)	(Give	dent's Usual Occupation kind of work done during I O NOT use retired)	most of working		. Kind of Busines	s Industry			
Elementary/Seconday (0-12) 8 Years	College (1-4 or 5)+)	Nurse			Veterans Hospital				
17. Father's Name (First, Middle, La	ust)			Nother's Name (First,						
Frank Cavave	•		10. 14	Mary War		sii Surriarriej				
19a. Informant's Name/Relationshi		405 14-15								
Andrew T. West		821	ng Address <i>(Street and Nu</i> O North Poin	imber or Hural Houte it Road E	Number, City Edgemer	e, Mary]	Zip Code) Land 21219			
20a. Method of Disposition		20b. Place of Dispo		Date	20c	Location - City of	or Town. State			
1 🔀 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sc			matory or other place) dge Mem. Par	1 2/19/20		Elkridge				
21. Signature Formal Service Lie		Y 11	2. Name and Address of Fa		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	11101 146	5, 125			
that 1	WIN		uda-Ruck Fur 1922 Wise Av	neral Home	of Du	ndalk,	Inc.			
23a. Part 1. Enter the disease, or o	omplications that caused					ryland Z	1222			
shock, or heart failure. List or Immediate Cause (Final	ly one cause on each line).	or the mede of dying, eder	ras cardias or respii	atory arest,		Approximate Interval Between Onset and Death			
disease or condition resulting in death)	_a _ S+tc	CK					Onset and Death			
and the second s	Due to (or as	a consequence of):								
Sequentially list conditions,	b. —									
if any leading to immediate cause. Enter Underlying	Due to (or as	a consequential offi								
Cause (Disease or linjury that initiated events	C. Due to (ov so									
resulting in death) Last	Due to (or as a	a consequence of):								
	d									
F FEMALE:							-			
23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome		Ectopic pregnancy			23d. Date of d	elivery			
1 Yes 2 No	4 ☐ Pregnant a 9 ☐ Unknown	t time of death 5	Other (specify)			Month	Day Year			
9 Unknown										
Part II. Other significant condition		ut not resulting in the u	nderlying cause given in P	art I. 23			to the cause of death?			
ADVANCED D	EMENTIA	, AORTIC	C STENOS	15	1 🗌 Yes	2 No 3 □ 1	Probably 4 🗌 Unknown			
HTW				24	la. Was an	24b. Were a	utopsy findings available			
					autopsy performed?	death?	completion of cause of			
25. Was case referred to medical			26 Place of I	Death (Check only or	Yes 3	No 1	es 2 No			
examiner? 1 ☐ Yes 2 ☑ No	Hospital:	not 20 ED/O-4	- Other							
	I 1 □ Inpatie	ent 2 ER/Outpatien	nt 3 L DOA I ⊿	Nursing Home 5	Basidanca	6 Other (Spe	oifu)			

Pnysician/ Medical Examiner

Examine

Certificate: To Be Completed by Physician/Medical

Medical

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itien 27: is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at

Director

Funeral

Completed by

Be

မ

Physician/ Medical

Examiner

Funeral Director

or 28a-f shov

To the Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran within 24 hours after death.

To the Funeral Director: After this certificate

Division of Vital Records, P.O. Box 68760

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		230
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use
ADVANCED D	EMENTIA, ADRTIC STENOSIS	1 ☐ Yes 2,	P
HTW		24a. Was an autopsy performed?	0
25. Was case referred to medical examiner?	26. Place of Death (Check or		
1 ☐ Yes 2 ☑ No	Hospital: Other:	_	

27. Manner of Death 28b. Time of 28c. Injury at

28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei only one 29b. Signature and title of certifier

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAROLINE D'SOUZA , 5601 LOCH RAVEN BLYD, BALTIMORE MD-21239

RES 000

29d. Date signed (Month, Day, Year)

2010

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 19 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Williams Anna V. 20/0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ose Baltin Sa Maro If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 26, 1949 9. Birthplace (State or Foreign last birthday) . Social Security Number 218-60-5012 7. Age (In yrs **Funeral** Months: Days Hours Min. 1 □ M 2 🛛 F 60 MD Director Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examination must be notified at Director MD Baltimore Essex 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 408 Lorraine Avenue 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No if Yes, Give Year or Dates: Specify: White 2 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Daycare Provider Child Care 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Phaller Sherman Dawson Sr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trauonce. Pages 1 and 2 408 Lorraine Ave. Baltimore MD 21221 Ami Withrow /daughter 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 2/19/10 Bayview Crematory Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Ave of . Balto MD Essex 21221 Mace das Connelly Funeral Home 23a. Part 1. Enter the disease, or complexitions that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Subarac 0 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner be executed as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. physician Physician/Medical The law requires that the death certificate attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? for Month Year Day 5 ☐ Other (specify) Ö the detached 9 Unknown by σ. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform certificate 2 No Division of Vital 1 ☐ Yes 2 (XV) 1 ☐ Yes il or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 🗌 No the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a Hospital Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address

31. Date filed (Month, Day

M.D

mpleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per EH G900 2/19/2010 Jh. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Fe bruar Physician/ 2°010 08:20 PM MYRTLE WILSON Medical 4a. Facility Name (if not institution, give stre 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore HOSPI timore If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)

MD **Funeral** Months Days Hours Min. 04-08-1917 Director 213-80-9178 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1x Yes 2 ☐ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1803 THORNBURY RD. USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Deceue... Armed Forces? Yes 2 **X** No 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: WHITE If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 0 DISABLED NONE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ GIIS BLAKELEY ALICE BURTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LA VERNE BROOKS/CASE MGR. 1803 THORNBURY ROAD, BALTIMORE, MD 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Baliton, characteristicon) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 02/19/2010 02/19/2010 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS STREET, BALTO., MD 21217 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hypoxemic disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, To the Hespital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No been signed by the should be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be B 26. Place of Death (Check only one) 2 🗷 No 1 🗌 Yes Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending Accident Suicide Investigation

Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, within 24 Hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tanagiotis Sinai Hespi (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Known

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04594 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Year 50 2010 3 HELEN WILLIAMS Ε. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE UNION MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min. 1/17/13941° Director 69 MD 219-38-1268 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 🕱 Yes 2 🗌 No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21225 3425 ROUND ROAD death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes. Give "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates BLACK permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC HOUSEWORK Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 NATHANIEL JACKSON IRENE GAMBRILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KEVIN SNOWDEN/SON 8825 WINTERBROOK RD. RANDALLSTOWN, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CREMATION CNTR. 2-20-2010 BALTIMORE, MARYLAND Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physicianz disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner pringly Sequentially list conditions if any, leading to immediate cause. Enter Underlying Exami or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or iinjury olistridium and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 attending IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ξ in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year been signed by the should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 2 No 1 X Yes 2 □ No 1 🗌 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation 1 Yes 2 🗌 No Accident 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 24 2 PM Hogg within 2 To the I only one) 29c, License number

State

32. Registrar's Signature

Union Memorial Hospital

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Al Chatrit

31. Date filed (Month, Day, Year)

Registrar

Univ

1, Baltimore, MD 21218

201

E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and #286 Per Phy &FH G901 3/02/2010 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year **Physician** WILSON 02 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death Eacility Name (If not institution, give street and number) Examiner Bultranove altimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 0523 75 34 VA 09 29 Director יצ Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show at 1 X Yes 2 □ No "natural", or items 23a or 28a-f sl' edical Examiner must be notified MD NA Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2 should be filed within 72 hours after death with in and Mental Hygiene.
is marked other than "natural", or items 23a or ? 21217 U.S.A. 1230 McCulloh Street Apt #1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 🌂 Married Black 1 ☐ Yes 2X No 3altimore, Maryland 21215-0036 Specify: ò 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Company Truck Drive 9th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental I Important: If Item 27 is meriany or other: Be Julian Wilson Mary Penn ۴ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3302 Piedmont Ave, Baltimore, Md 21216 Mary Anna Simmons-Sister Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Aonation 5 ☐ Other (Specify) 2/23/10 Baltimore, Md On-Site 22. Name and Address of Facility 21. Sign ture of Funeral Service Licensee March F/H West 21215 4300 Wabash Ave, Baltimore, Md Enter the disease, or complications that caused the death.

k, or heart failule. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1 shoc Immediat Cause (Final disease or condition resulting in death) Physician 610- Vascu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Completed by 2□ No 1 Xes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has trector, page 2 s performed 25. Was case referred to medical examiner? funeral director 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → 1 🔲 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: /
completely filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. To the I 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

FEB 19

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Regist

.O Conne

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ EVELYN WELDINGER 20: 24 PM JEAN 2010 FEBUANT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHNS HOPKINS BACTIMORE BAYVIEW MEDICAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months 07/01/1946 Maryland Director 218-44-8926 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A. 2130 Southorn Road 21220 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 Yes 2 No Specify: White 3 X Widowed 4 □ Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Homemaking Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Arthur Barnette Margaret McInturff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 907 B Montana Circle - Seattle, Washington Christopher M. Covahev (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 02/18/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 6 11750 Belair Road - Kingsville, Maryland an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final PHEUMONIA WEEK Medical resulting in death) Due to (or as a consequence of): Examiner 1 MONTH MENINGIOMA Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami executed the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed

Physician/

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 been signed by has After this certificate

Certificate: To Be

Medical

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 1 No 1 Yes 2 No 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MEDICAL

CENTER

29c. License number RES - 000 29d. Date signed (Month, Dav. Year) FEBURNY 16, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAN LIMHOD HOPKINS BAYVIEL

31. Date filed (Month, Day, Year) FEB 19 2010

29b. Signature and title of certifie

25. Was case referred to medical

2 1 No

5 Pending

Investigation

determined

6 Could not be

1 🗌 Yes

27. Manner of Death

Matural

3 Suicide
4 Homicide

only one)

29a. Certifier

Accident

32. Registrar's Signature

MD

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

State

within 24 hours after deat To the Funeral Director:

filled in by

State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month 5-15AM 2010 Medical institution, give street and number) **Examiner** 4b. City, Town or Location of Death 4c. County of Death 15a Himore rvington rs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😿 F Months Days Hours Director 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🔀No timore 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; 1 Yes 2 No Specify: 3 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Maiden ည sor 20a. Method of Disposition 20b. Place of Disposition (Na 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State any injury or 20-10 4 ☐ Donation 5 ☐ Other (Specify) 21. Sigr 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician, did disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Stag Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 9 Unknow 9 Unknown Records, P.O. by signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician; The law requires 2 No 3 Probably 4 Unknown 1 Yes within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforr 21-No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 3 🗆 DOA မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of pu rson who completed cause of death (Item 23a) (Type, Print) 2 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 2 Markel

29d. Date signed (Month, Day, Year)

Place Dundalk MD

and manner stated.

who completed cause of death (Item 23a) (Type, Print)

amend #9, 14, 15 of Maryland Department of Head BD C901 3(05/2010 JH For State amend items 12,16a,b,17,20a-c 22 per fb 901 3-23-10 vt Registrar Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2010 Douglas Woodruff 4:12 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton If Under 1 Year I If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, av 30. 1 🖾 M 2 🗆 F Months Days Hours Min Maryland **Director** 578-44**-**0510 74 1/935 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges Hyattsville 1 ☐ Yes ¾☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>2305 Bellview Avenue</u> 20781 USA Page 1 and 2 should be filed within 72 hours after death vacent of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 111 Yes 2 No If Yes, Give 11. Marital Status - unit Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Vivorced Specify: Year or Dates the Medical 16a. Decedent's Usual Occupati 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) -unk 10 unk 0 Manufacturing Carpenter Factory Worker alth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Lastunk 18. Mother's Name (First, Middle, Maiden Surname) unk-Douglas Douglass ၉ Nathaniel Woodruff Sr. Anna Fowler 19a. Informant's Name/Relationship (Type, Print) Address (Street and Sumber of Paral Fourte Number City 07746, State, Zip Code) Beverly Barnes/neice Surratts Road; Clinton, MD 20735 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If ii
any injury or o ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation Ft. Lincoln Crematory 3-18-10 Brentwood, Md. Signatur of Funeral So Ronal Lu Name and Address of Facility Ft., Lincoln Funeral Director Bladensburg Rd', Brentwood, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or c Medical resulting in death) Examiner CHONAN Sequentially list conditions, Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 5 Other (specify) Month Year Pregnant at time of death Day 1 Yes 2 No certificate has been signed by the irrector, page 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Floor after death.

Funeral Director: After this ce Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No မှ 1 ☐ Inpatient 2 🗶 ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a

To the Funeral I

completed filled 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) 32. Registrar's Sig State FEB 19 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elizabeth Weigand February 20 1 0 4:30 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral 9. Birthplace (State or Foreign Jan 14, 1 M 2 X F Days Hours 217-16-3705 87 Mary Land Director Yrs Ĩ923 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Timonium 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21093 2525 Pot Spring Rd; Unit S712 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married FEBRUARY 5, 2010 4:30 p Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patrick John McDonough Sr. Marie Streb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Weigand/son 5312 Palm Dr.; LaCanada, California 91011 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Signatur Servi State Anatomy Board; 655 W. Baltimore Street Baltimore. Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ASPIRATION PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of. Exami burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Vital Records, P.O. Box 68760 as IF FEMALE use yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident Investigation within 24 hours after death To the Funeral Director: completed filled in by the 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

ELIZABETH

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

30. Name and agdress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CRNP

JACKIE JONES.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	ryland /		rtment of H tificate of D		d Mental Hy	giene Reg. No. 2 (010	04601
	Dhusisis	/	Decedent's Name (First, Middle, La	st)					2. Date of De	ath	Voor	3. Time of Death
	Physicia Medic		ELEANOR CLAIRE WI						FEB.	f_4^{ay} ,	20°110	12:55 P M
	Examin	er	4a. Facility Name (if not institution, giv GILCHRIST HOSPICE			4b. City, Town, or TOWSON		ath		nty of Death		
	Funeral		Social Security Number 6. 5	Sex 7. Age (In yrs. last b		If Under 1 Year Months Days	If Under 24 H Hours Mi			9. Birthplace (State or For	
М	Director		214-18-9112 Usual Residence of Decedent	^{1 □ M 2 □ F} 88	3	Yrs.	Months Days	THOUSE IN	SEPT.	3, 1921		MD
700	show dat	tor	10a. State 10b. County		10c. City, To	wn or Loc	ation	<u>-</u>				10d. Inside City Limits
Mon	28a-f	Director	MD N/A		BALT	IMOR						1 XYes 2 No
4+4+	3a or the n		10e. Street and Number				10f. Zip Code 21206			10g. Citizen o	of What Cou	intry?
4	ems 2	Funeral	5716 CEDELLA AVE	12. Was Decedent Eve	er in U.S.	13. W	as Decedent of Hi	spanic Origin?	(Specify Yes or No-		ace - Ameri	can Indian,
Maryland 21215-0036	e filed within 72 hours after death with the Maryland Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ XN If Yes, Give Year or Dates.	0		Yes, specify Cubar ☐ Yes 2X No		erto Rican, etc.)	Speci	lack, White, ify: WH	
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s, Mal	of Health and File the fitem 27 is r		19a. Informant's Name/Relationship (PAUL WLODARSKI—S	, , ,		5716	CEDELLA		Rural Route Numbe BALTIMORE	E, MD 2	1206	
Baltimore,	permit. rage 1 and 2 should be in Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec	☐ Removal from State ify)	ceme	etery, crem STANI:	ition (Name of atory or other place SLAUS CEN	1. 2/	Date 19/10		IMORE	, MD
Balt	Depart Import any inj once.		21. Signature of Funeral Service Licer	isee	>		Name and Addres			ZEILEI		SON, INC 224
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8/6 History	ng phy as the		IF FEMALE:									
DIVISION Of VITAL RECORDS, P.O. BOX 68/60	within 24 bours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	☐ Fetal de		Ectopic pregnanc Other (specify)	у			Date of deli Month	very Day Year
S, F.O.	signed by	by	Part II. Other significant conditions	contributing to death but	not resultir	ng in the ur	nderlying cause giv	en in Part I.				the cause of death?
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	fter this	ate: To	27. Manner of Death 1 Natural 5 □ Pending	1 Inpatien 28a. Date of injury (Month, Day,	281	Outpatient o. Time of injury	28c. Injury	4 ∐ Nursing	g Home 5 Resi			by Ites, ice
IVISION or Attend	after death	Certificate:	2 ☐ Accident Investigation 3 ☐ Sulcide 6 ☐ Could not 4 ☐ Homicide determined	be 280 Place of Injun		, farm, stre		Yes 2 □ No	28f. Location (nber or Rura	al Route Number,
Hospital	24 hours Funeral leted filled	Medical	(Check 2 Medical Exar	ysician: To the best of m niner: On the basis of exa rse Practioner: To the basis	mination an	d/or investi	gation, in my opinio	n, death occurre	ed at the time, date	and place, and o	due to the c	ause(s) and manner stated.
To the	vithin To the	2	29b. Signature and title of certifier		sst of my kin	owicage, a	29c. License	number	place, and due to the	29d. Date sign	ned (Month,	Day, Year)
	4		30. Name and address of person who	completed cause of dea	ath (Item 23	a) (Type, Pr	rint)			Fibria	2 12	4010
	' \		March Grant, 31. Date filed (Month, Day, Year) FEB 19 2010	6/01 N. (b	Signatus	54,	1060501	, MD	21204			
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			For State Registrar		State o	f Marylar		artment of I rtificate of	Health and I <i>Death</i>		giene Reg. No 20	10	0460	0 2
	Physicia		1. Decedent's Name							2. Date of De Month	ath Day ARY O9	Year 2010	3. Time of De	
	/Medic Examin		4a. Facility Name (I		n, give street and nu	mber)	-		or Location of Death	E	4c. Count	y of Death		
	Funeral Director		5. Social Security N 218-14-16 Usual Residence of	552	6. Sex 1 X M 2 □ F					8. Date of Bir (Month, Da JUNE 2	th Year) 6,1923	9. Birthp Court MARY		oreign
	faryland f show	or	10a. State MD	10b. County	LTIMORE			1	0d. Inside City L					
	or 28a-	Director	10e. Street and Nur				SATONSV	10f. Zip Code	1228		10g. Citizen of	What Cour	itry?	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Maryland sitem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination and the notified at	eted by Funeral	6348 FR 11. Marital Status 1 XNever Marri 3 Widowed (Specification)	ied 2 ☐ Marr 4 ☐ Divorced	12. Was Dece Armed Fo 1 ∐Yes If Yes, Gi Year or D	2 ∏X No ve	16a. Dece	Was Decedent of If Yes, specify Cub 1 □ Yes 2 ▼No	Hispanic Origin? (S pan, Mexican, Puert Specify:		or No- 14. Race - American Indian, Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry			
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Baltimore, l	Pages 1 and 2 ent of Health nt: If item 27 i ry or other tre		GEORGE L 20a. Method of Dis 1 X Burial 2 4 □ Donation	position Cremation	3 Removal from	Siate I	Place of Disponentery, cre	SILVER Societion (Name of matory or other place) EEMER CEN	i	AD PERRY Date 5/2010	20c. Location	- City or To	wn, State	
Baltii	permit. Pages 1 Department of 1 Important: If ite any Injury or of		21. Signature of F			,	2	2. Name and Addr	ess of Facility MI	[LLER-D]	PPEL FU	JNERAL	MARYLAN HOME	D
EST	Physician /Medical Examiner	<u>.</u>	Immediate Cause disease or condition resulting in death)	(Final on	Due to	TRAVE	th. Do not en		ing, such as cardiad				Approximate Interval Betwee Onset and Dea	ath
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	Sta Registra		31. Date filed (Mon	th, Day, Year)	-	! - l								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 12 Feb. ANNIE В. WATERS 2010 2220 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft. Washington Hospital Prince Georges Washington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Months Days Hours 1 ☐ M 2 🕮 F 424-56-2385 66 Jan. 31, 1944 AT. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Prince Georges Ft. Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 302 Ironshire Pl. 20744 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: þ Specify: 3 ★ Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Human Resources Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eliea Baker ပ Ida Mae Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Celestine Sneed - Friend 3212 Highwood Dr. SE Washington, DC 20020 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 3-1-2010 Cheltenham, Md. 22. Name and Address of Facility
Marshall's Funeral Home of Maryland 21. Signature of Euneral Service Licenses 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) < Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for as a consumero off Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 TVoc 2 TNo 3 T Probably 4 THeknown

Physician /Medical Examiner

attending physician a for use as the burial

the

by t

has

requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician

Funeral

Director

27 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Wedjon Evan in an must be mylffed at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Item M.

Baltimore, Maryland 21215-0036

Examiner Physician/Medical been signed the should be detailed þ Completed certificate ha Be

eq			Thes 2 ho of Hobbs y
Completed			24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 □ Yes 2 □ No
Be	25. Was case referred to medical examiner?		26. Place of Death (Check only one)
2	1 Yes 2 No	Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Othe	er: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
	27. Manner of Death 1 → Natural 5 → Pending 2 → Accident investigati	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work M 1	.?
Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)
edical (ne, date and place, and due to the cause(s) and manner as stated. pinion, death occurred at the time, date and place, and due to the cause(s)
ž	29h Signature and title of certifier	29c License	e number 29d Date signed (Month, Day, Year)

29b. Signature and title of certifier

45365

29d. Date signed (Month, Day, Year) 02-15-2012

iving Star 11 H 101, fort LAIListan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) .M.D 4/lous

Registrar

State

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amen State Amen Registrar	d Item	25 per m	f Maryla e,g900	nd / Depa ,02/18/ <i>Cer</i>	rtment 2010ah tificate	of H	ealth a eath	and M	lental Hy	gien Reg. N	e201	0	04604
	Physici Medi	cal	1. Decedent's Name	(First, Middle,	Last) ZEL	LNER						2. Date of De Month	ath [Day Yea		3. Time of Death
	Exami		4a. Facility Name (if I	PILING P	ATVIEW V	MEDICAL		4b. City, To	BY	Location o		Re-	4	c. County of De	eath	
	Funeral Director		5. Social Security Nu 216-36- Usual Residence of I	-2121	i. Sex 1 □ M 2 🗹 F	7. Age (In yrs.	last birthday) 70 Yrs.	If Under 1 Months [Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Mar	th <i>y</i> 31°,	1939	New New	ce (State or Foreign York
	/aryland 8a-f show tified at	Director		10b. County	imore		ty, Town or Loc								100	I. Inside City Limits
	s 23a or 2 s ust be no	Funeral Di	10e. Street and Number 7815 Fa		n Road			10f. Zip Co	ode 1222	2	100		10g. C	Citizen of What C		r?
920	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	\$	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed 4	•	12. Was Deced Armed For d 1 Yes If Yes, Give Year or Da	ces?	If	/as Decedent Yes, specify	Cuban, -	Mexican,	in? (Spec Puerto R	ify Yes or No- lican, etc.)		14. Race - Ar Black, Wh	nite, etc	
Baltimore, Maryland 21215-0036	hin 72 hour ne. than "natur te Medical.	Completed		15. Decedent' ify only highest			(Give ki life. DC	ent's Usual C ind of work of NOT use re	one du lired)	ring most	of workin	g	16b.	Kind of Busines		
land 2	should be filed within n and Mental Hygiene. 7 is marked other tha raumatic event, the N	To Be C	17. Father's Name (Fi	rst, Middle, Las m Plage			Bus	iness		18. Mother		(First, Middle, te Gol		,		
e, Mary	O = 5: =		19a. Informant's Nam Jeanett	e Smit	(Type, Print) h /Daugtht	er	19b. Mailing	Address (St 211 Fr	reet an	d Number dly F	or Rural Road	Route Number Hornto	; City o	r Town, State, 2	Zip Cod 395	de)
Itimore	t. Partmer		4 ☐ Donation 5	Cremation 3		State C	Place of Dispos cemetery, cremo Chesape	ake Cr	place)	tory		dan 25 2010	,			, State Maryland
Ba	Depart Depart Import any ir		21. Signature of Fune	da de	e Rit	ter		8717	Gree	n Pas	ture	eral Al	Tov	atives son Mar	ylar	nd 21286
	Physician/ Medical		23a. Part 1. Enter the shock, or heart Immediate Cause (Fi disease or condition resulting in death)	railare. List Only	a. NT	n iine.	- RICULA		i i	such as ca			est,		In	oproximate terval Between nset and Death
	L aminer	iner	Sequentially list cond if any, leading to import cause. Enter Underly	ditions,	b	r as a consequ						16	2	MINER		
0	The law requires that the death centilicate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):									TOTAPPION	OVED STIED	CITE			
58760	ertificate ling phys se as the	/Medical	IF FEMALE:		d											
O. Bdx 68	t the death certific by the attending tached for use as	Physician/M	23b. Was decedent pr in the past 12 mo 1 Yes 2 I I 9 Unknown	onths?	23c. If yes, outco	irth 2 🗌 Feta ant at time of c	i death 3 🗌	Ectopic preg Other (specif						23d. Date of de Month	elivery Da	y Year
ds, P.C	w requires that is been signed be should be deta	≦	Part II. Other significa	ant conditions	contributing to dea	ath but not res	ulting in the und	derlying caus	e given	in Part I.				use contribute t		ause of death?
Division of Vital Records,	certificate has be rector, page 2 sh	Completed	05.14							·	_	24a. Was an autops perform	sy med?_/	prior to death?	comple	findings available etion of cause of
Vita	nis certii directo	To Be	25. Was case referred examiner? 1 X Yes 2	/	Hospital:	patient 2 🗆	ER/Outpatient		Other	of Death				Other (Spec	-16.1	
ion of			2 Accident	5 Pending Investigation 5 Could not	28a. Date of (Month,	injury Day, Year)	28b. Time of injury	28c. li v M 1	njury at vork? Yes		280	d. Describe ho			ситу)	
DIVIS	eral Direc		4 Homicide	determine	28e. Place of building	, etc. (Specify)						City or Town	, State)			ite Number,
To the Hee	within 24 h	Med		Certifying Nu	ysician: To the bes niner: On the basis rse Practioner: To				t the tin	ne, date an		e time, date and and due to the	d place, cause(s	and due to the and manner as	cause(s stated	s) and manner stated.
			1 Dr	ne	8 ب	58		2		· 00	9			e signed (Mont.	23	2010
	7)	- 1	SO. Name and address SHYIAN 11 Date filed (Month F	JEN	1 491	10 t	PASTE		qve	WUE	- 1	PACTIV			Δ.	21224
	State Registra	r	1. Date filed (Month, D	9 2010	32. Regi	strar's Signate	fall	0						,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 February 1:54P M Theodore G Zakotnik Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring 3213 South Leisure World Blvd., #2D Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Apr. 5, 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 6. Sex **Funeral** Hours 1 X M 2 □ F Minnesota Director 520-14-7340 88 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 3213 South Leisure World Blvd., #2D United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 A Yes 2 If Yes, Give Black, White, etc. 2 □ No World ģ 1 ☐ Never Married 2 🗓 Married be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: War II White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) United States and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Postal Service U.S. Postal Service Supervisor 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Babnick Josephine Michael Zakotnik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 525 Lynch Street, Rockville, Maryland Linda Z. Morgan/Daughter Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) February 19, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 D Other (Specify) Crematorium, Inc. 2010 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature Principal Service Life in ee M00803 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Eetweer Onset and Death Immediate Immediate Cause (Final Physician Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Years Coronary Artery Disease Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Years law requires that the death certificate be executed attending physician and for use as the burial-transi Essential Hypertension that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Yes 2 No ed by the a detached f 1 ☐ Yes 2 L 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law requires that within 24 hours after death.

To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det Completed by Cerebrovascular Disease 1 X Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an Renal Insuffiency prior to completion of cause of death? performed?
1 Yes 2 No Hospital or Attending Physician: The 1 🗌 Yes 2 🗆 No e B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 No Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month. Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Burt Ira Feldman, M.D.

State Registrar (Check

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D23958

3305 North Leisure World Blvd., Silver Spring, MD 20906

29d. Date signed (Month, Day, Year) February 16, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Salvatore Attanasio Physician/ February 2, Day 2010 3:30 р м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Hours 1 X M 2 □ E Jan. 1, 1921 Director 579-12-8050 Italy Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Laurel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15601 Bradford 20707 USA Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, "natural", or 1 Never Married 2 Married 1√ Yes 2 No If Yes, Give Completed by Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Nidowed 4 Divorced . De filed wtu..
Mental Hygiene.
'ed other than "natu..
'et the Medical Ey 1942-46 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Barber Shop Owner Be permit. Page 1 and 2 should be filed Der artment of Health and Mental Hy Important: If Item 27 is marked ott any Injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Attanasio Maria Leardo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15601 Bradford Drive, Laurel, MD 20707 Lucia M. Hill/Daughter Barlimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cate of Heaven Cemetery Feb. 2010 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²Transals Agdrescoffilms Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the Auth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner MONI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year 5 Other (specify) PO Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 2 🕏 3 □ Probably 4 □ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 2 **P**No 1 Tyes Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 K No Certificate: To 1 ♥ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. E Funeral Lirector: A lited filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Set trying Prijection: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2.

the F. only one) 29b. Signature and title of certifier 440 DO05 7124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Truong Bao, MD 101101 Molecular Drive, #206, Rockville, MD 20850 Truong Bao, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

3:300

FELICIARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Dav Year **Physician** usei 725 Jan 15 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Martgomer Takoma *
If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) ton MIK Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours Gicountry) 1 M 2 □ F 579-15-3432 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County in then "naturel", or itema 23s or 28s-f ehow the Medical Examiner must be notified at Prince 1 Yes 2 NO Director Hyattsville Maryland Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20183 UT. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 Oo o If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 77 is marked other then traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Never worker None 5 VIS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ould be Mentai ss 1 end 2 should be of Health and Mental Item 27 is marked unavailable unavailable 2 9a. Informant's Name/Relationship (Type, Print), Bro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suitland , MO 26746 3710 Deming Dr. Sie 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Deportment of H
Importent: If Ite
any njury or ot 1 ■ Burial 2 □ Cremation 3 □ Removal from State tenwood Cemetery unavailable Washington 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address Facilin Genesis Cremation And Quineral 21. Signature of Euneral Service Licenses 732 GA. wash, DC 20011 Ave NW Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac of respiratory arrest, ons that caused the Tyse on each line. 23a. Part1. En the disease, or complete shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Physician Tulmonar minute /Medical Due to (or as a consequence of) Examiner Retoget dosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ue to (or as a consequence of) Examine certificate be executed ettending physician and for use es the burial-transit ertensi Due to (or as a consequence of): resulting in death) Last 68760. Physician/Medical Box (IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) P.0. been signed by the should be deteched 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. δ Records, 1 Yes 2 No 3 Probably 4 Dunkhown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate hes t lirector, page 2 s autopsy 2 No 2 🗆 No 1 ☐ Yes of Vital director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examines? 1 ☑ 1es 2 ☐ No Hospitaf: Other: 1 patient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Injury s after decret Altery to the fur 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō To the Hospitel within 24 hours a To the Funerel C 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Daye signed (Month, Day, Year) 29b. Signature and little of co Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 DID CENTURY 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) Type, Print) BARRERA

DHMH 17 Rev 1/2001

200

m.D.

2. Registrar's Signature

29c. License number

GLENNST

29d. Date signed (Month, Day, Year)

State

Registrar

FEB 19 2010

32. Registrar's Signature

	4
10-01143	

Beatrice Renee Anderson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland	/ Department of He	alth and Mental Hygiene

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		1- For State Registrar		Ce	rtificate o	f Death		, ,	Reg. No.	
Physici ledical Exam		1. Decedent's Name (First, Midd		r Ander		2. Date of Death Month Pay Year February 8, 2010 3. Time of Death 0744 hrs				
<u>ر</u>		4a. Facility Name (if not institution Union Hospital	n, give street and n	umber)		4b. City, Town, or Elkton	Location of De	ath	4c. County of Cecil	of Death
Funeral Director		5. Social Security Number 216-04-7640	6. Sex	7. Age (In yrs. 26	last birthday) Yrs	If Under 1 Yea Months Days			Birth(MM/DD/YYYY	y) 9. Birthplace (State or Foreign EIKTON Country) Maryland
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral Director	Usual Residence of Decedent 10a State	Road 12. Was De	cedent Ever in U					10g. Citizen of Who	10d. Inside City Limits 1 Yes 2 X No nat Country? States - American Indian, Black,
after al", d	Completed by Fu	3 Widowed 4 Div 15. Decedent's Education (Special Elementary/Secondary (0-12)			during m	Yes 2 No	ion (Give kind		16b. Kind of Bu	White siness/Industry
21215-0036 hould be filed within 72 nd Mental Hygiene. is marked other than "	Be	17. Father's Name (First, Middle, David Franklir 19a. Informant's Name/Relations	Carter				Kimbe	rlv Cau	I Own Ho , Maiden Surname dill)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be flight within 72 hours Department of Health as Mental Higgine. Important: If item 27 is marked other than "natur injury or other traumatic event, the Medical Exam	To	Daniel Carter / 20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation of Other Sc 21. Signatury Tuneral Septice	Uncle 3 Removal for secify: Licensee	rom State Eb	433 Mc Place of Dispos crematory or oth enezer 22. N	CGrady Ro ition (Name of cer her place) Cemetery lame and Address	oad, Ri	sing Sun Date ebruary 5, 2010 rouch Fu	Maryla 20c. Location - Rising neral Hon	n, State, Zip Code) nd 21911 City or Town, State Sun. Maryland me
Physician Medical Examiner		23a. Parf I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. Narcot	ic (mor	phine)	<u>South Mode of dying,</u> intoxica done use				Approximate Interval Between Onset and Death
uted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	С.	a consequence of						
68760, errificate be executed ding physician and east the burnal - transit		X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	e 1 Live t	outcome of preg pirth	nancy 2 Fe	ermE, g9	00 2/22 Ectopic pres		23d. Date of Month	delivery Day Year
O. Box 68' at the death certiff d by the attending tached for use as	/ Physicial	1 Yes 2 No 9 Unk	nown 9 Unkn		3 Oti	ner (Specify)	iven in Part I.	23e. Did	tobacco use contri	bute to the cause of death?
Vital Records, P.O. hysician: The law requires that the this certificate has been signed by all director, page 2 should be detach	Completed by							24a. Wa auto	s an 24b. V	Probably 4 Unknown Vere autopsy findings available nor to completion of cause of eath?
tal Re	Be Co	25. Was case referred to medical examiner?	PERSONAL PROPERTY.	10.432	D		of Death (Che	-	2 No 1	Yes 2 No
ing P After funera	Certification: To	- X	28a. Date (Month tigation Fd 2)	i, Day,Year) /8/10 æ of Injury - At h	Fd 6:35	njury 28c. Injury 28c. Injury 28c. Injury 28c. Injury 3 cm 1 Y	y at Work?	28d. Describe unk 28f. Location		er or Rural Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only 1 Certifying Ph	mined (Specify) ysician: To the besininer: On the basis	st of my knowled	at resi	red at the time, da	te and place, a	nd due to the cau	use(s) and manner	as stated.
Tot with Tot comp	Medical	290 Signature and title of certified to the certified of	and manner s	Laborated.	U	29c. License O.C.N	number	- stare unte, uat		ed (Month, Day, Year)
St	ate	Victor Weedn MD JD 31. Date filed (Month, Day, Year)	Assistant Me	dical Examin		enn Street, B	altimore, M	D 21201		
Regist	rar		nan A	me f	Back	011				
DHMH 17 Rev 1/2	001		DOME	12	ŐŔĬGINAI	L				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ → Monti Ann G. Aluise 6:40 a M ian war Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctor's Community Hospital Lanham Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏻 F Months Days Hours Min. Director 195-18-0751 87 Pennsylvania May Usual Residence of Decedent nt of Health and Mental Hygiene.

Lift item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must have acted. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland | Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 89 Herrington Drive 20774 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ☐ Yes 2X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Private $\mathbf{B}_{\mathbf{e}}$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anastasia Defazio Joseph Gerardi 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Aluise (Daughter) 2260 Four Seasons Drive, Gambrills MD 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3X Removal from State Feb 4, 2010 O'Hara Township, PA 4 ☐ Donation 5 ☐ Other (Specify) Mary's Cemetery Signature of Funeral Service License 22. Name and Address of Facility Latimore Funeral Services, P.A. Patrici atemore 9013 Annapolis Road, Lanham MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury n Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident
Suicide
Homicide Investigation 24 hours after deat Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number determined Medical 29a. Certifier 1 Coertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of∧ 29c. License number 29d. Date signed (Month, Day, Year) MDJ 606 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N 8118 Good Luck Rd. Lanh 31. Date filed (Month, Day, Year) State 2010 FEB () Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2\, 0$ 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 1/27/2010 1808 FREDERICK LEE ADAMS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S CHEVERLY PRINCE GEORGE'S HOSPITAL 8. Date of Birth (Month, Day, Year) 2/15/1957 Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday, **Funeral** Days Hours txXM 2□ F Yrs Washington, 52 Director <u>578-78-6648</u> Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must but withing at 1 Tx Yes 2 □ No Be Completed by Funeral Director Maryland Prince George's Capital Heights 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 5610 Prescott Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 Yes, Give 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔼 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Silver Cab 12 <u>Cab Driver</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Marie Carey Frederick Lee Adams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) Heights, Maryland 20743 5610 Prescott Ct. Capital Callestine Adams / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, Maryland 2/8/2010 4 Donation 5 Other (Specify), Maryland Veterans 22. Name and Address of FacilityPope Funeral Homes, P.A. 21. Signatur of Funeral Service Lices 5538 Marlboro Pike Forestville, Maryland 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due consequence of) Examiner or Attending Physiclan: The law requires that the death certificate be executed burial-transit and Due to (or Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year Month Dav in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No detached 9 ☐ Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause giver In Part I 2 2. No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2. autopsy performed 1 ☐Yes 2 ☑No 2 🗆 No 1 Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 □ No Certification: To funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27 Manner of Death Injury (Month, Day, Year) 1 Natural 5 Pending investigation 15 1 □Yes 2 DNO Atcc after death. Q 2 Accident the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State) 3 Suicide in by determined 4 Homicide STreeT Mign PlagsAnl Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 81 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State FEB 0 3 2010 Registrar

Maryland 21215-0036

Baltimore,

Box 68760.

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 24, Patricia Ann Alexander 20ัวิซี 9:05 P **Physician** /Medical 4c. County of Death
Carroll County 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westminster Dove House 8. Date of Birth (Month, Day, Ye Apr. 27, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) , 1937 West Virginia **Funeral** 1□ M 2 F Days Hours Min 72 Yrs. 216-32-5313 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exposition must be rediffical at once. 10a. State 1 XYes 2 ☐ No Hampstead Director Maryland Carroll County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21074 4230 Crystal Court, Unit B1 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☐ No Specify. à 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Della Jane Hall Robert Ellis Hayes ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1331 North Main Street Hampstead, Maryland 21074 Haven Shoemaker, Jr./attorney Baltimore, Jan. 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hampstead, Maryland Carroll Cremation 4 □ Donation 5 □ Other (Specify) 2010 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service License Hampstead, Maryland 21074 934 South Main Street M01072 Lun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4maths **Physician** bosnau /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical the attending pl 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 14 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this After this funeral o 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation n 24 hours after death.

Re Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, th occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination a or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) npletely 2 Medical Examin To the I within 2.

To the F 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1/25/2010 WJL 30. Name and address of person wh gause of death (Item 23a) (Type, Print) costminster up 2157 31. Date filed (Month, Day, 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2010 10.28 PM Willard J Barbour Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day, Jan. 13 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. 1 ☑ M 2 □ F Hours Washington, Director 578-40-5720 78 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 X Yes 2 No Mt. Airy Maryland Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21771 1011 Jousting Way United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married à 1 X Yes 2 □ No If Yes, Give Year or Dates.Korea Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 1 and 2 should be filed within 72 of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) / President Auto Repair Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Kathleen Boswell Charles Elliott Barbour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21771 Douglas W. Barbour / Son 13688 Lexington Drive Mt. Airy, Maryland Baltimore, Department of Hea Important: If item 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment February injury Resthaven Mem Gardens 4, 2010 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee Mt. Airy, Maryland 21771 Ε. Ridgeville Blvd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final B Physician disease or condition Medical resulting in death) Due to (or s a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed entropen; that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month 4 Pregnant
9 Unknown Pregnant at time of death ed by the a 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, icate has been sig ; page 2 should b 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Depatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Tes 2 🗆 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continued Transfer Tr 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WO 51610 dire 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

2012VA

32. Registr r's Signature

aneu

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Amended#5pe	State of the FCHD	Marylar RG				ealth a Death		10	giene)	046	15
	Physici	an	1. Decedent's Name (First, Middle,								2. Date of De Jan-29		Ye	ar	3. Time of	
)	/Medic Examir	cal	BETTY JANE BR 4a. Facility Name (If not institution, y 14316 Tower R	give street and numb	er)			y, Town, or miths	Location of	f Death	Jan-29	4c.	County of D Frede:			. Ам
I	Funeral Director	V	5. Social Security Number 182-22-6177	. Sex 7. 1 □ M 2 □ F	Age (In yrs. 83	last birthday) Yrs.	If Und Month	er 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Aug • 2	th 19.	6 9.	Birthpla Count Mary	ace (State o	or Foreign
	death with the Maryland ms 23e or 28e-f show Entable notified at	tor	Usual Residence of Decedent 10a. State 10b. County Freder	ick		ity, Town or Lo nithsbu								10	d. Inside Ci	-
	h with the	Funeral Director	10e. Street and Number 14316 Tower Ro	ad			10f. Z	ip Code 21873	}			10g. Citizen of What Country? U • S • A •				
0-00-0	n 72 hours after death with the Marylan "naturel", or Items 23s or 28s-1 show silical Examir ar must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	∋s? 【∑No			edent of Hi ecify Cuba 217 No	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	No- 14. Race - American Indian, Black, White, etc. Specify: White			tc.	
0-0171	filed within 72 ho Hygiene. ther than "natur int, tra Mazical	Completed	15. Decedent's (Specify only highest Elementapy/Secondary (0-12)	Education grade completed) College (1-4	or 5+)	(Give	dent's Usual Occupation skind of work done during most of working DO NOT use retired) SSSET						ing F			
yland 4	a la b	To Be C	17. Father's Name (First, Middle, La Hampton Wolfe	st)							o (First, Middle, Smith	, Maiden	Sumame)			
, Mar	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	1 53	19a. Informant's Name/Relationship Wade Brown/Son			56	Kur	tis I			ng Wate				Code)	
Saltimore	Pages 1 ment of He ent: if iter ury or oth		20a. Method of Disposition 1 ∑XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		ate Mt	Place of Dispo cemetery, crer Bethe	sition (N	ame of cother place meter	y 2	2/1/2	2010		ville			
Dall	Departition of the control of the co		21. Signature of Funeral Service Lin	Spisee Leve	ag)	/			DATLE N STR		SON FU THURM					
,no/s	A be be executed with the burial-transit transit trans	cal Examiner	23a. Part1. Seter the discussion of or shock, or heart failure. List or timediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	as a consect	quence of):	er the mi	ing	A		or respiratory a		w		Approximat Interval Bet Onset and "Mu"n	ween Death
O. BOX 08/	death certific e attending pi id for use as i	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	a. 23c. If yes, outco 1 □ Live birth 4 □ Pregnan 9 □ Unknow	n 2 ∏ Feta tattime of o	aldeath 3□	Ectopic Other (pregnancy specify)					23d. Date of Month			Year
ras, r.	The law requires that the ate has been signed by the page 2 should be detache	by	Part II. Other significant condition	s contributing to deat	h but not res	sulting in the u	nderlying	cause give	en in Part I.			obacco u Yes 2	use contribu	te to the	,	leath? Jnknown
II Recor	: The law re cate has bee page 2 sho	Completed									24a. Was auto perfo 1 \(\text{Yes}		prior	to com	esy findings apletion of c	available ause of
<u> </u>	ysician: This certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth			(Check only o					
5	ling Phys	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of I (Month,		28b. Time of Injury		28c. Injury Work	at	1	me 5 Resi 28d. Describe			Specify)	
DIVISION	Atten or deat octor: by the	Certification:	2' Accident investiga 3 Suicide 6 Could no 4 Homicide determin	be 28e. Place of	Injury - At h , etc. (Speci	lome, farm, str fy)					28f. Location (Street an wn, State	d Number o	or Rural	Route Num	aber,
	To the Hospitel or within 24 hours afte to the Funeral Dir. completely filled in I	Medical (one)	Physician: To the be aminer: On the basi and manner	s of examina	owledge, death ation and/or in	vestigatio	on, in my op	oinion, deat	d place, a	and due to the ed at the time,	date and	place, and	due to	the cause(s	;)
	To To Con	2	29b. Signature and title of certifier Werryer	glna	1			9c. License カンジ	265				te signed (N	, ,	^	
	5		30. Name and address of person with MAW 2 AR.	J. SHz	AP7.	368	Print)	eel s	breil	1-1	Lege	You	019	07	21742	>
	Sta Registr		31. Date filed (Month, Day, Year)	32. Reg	istrat's Sign	ature A.	1	aread	,		~					

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

1	For State Registrar		of Maryland	•	tificate of				Reg. No	001	0	0461
an/	1. Decedent's Name (First,							2. Date of De Month	Da	ly Y	ear	3. Time of Death
cal ner	4a. Facility Name (if not inst	GHMAN BOYD titution, give street and nu	ımber)		4b. City, Town,	or Location of	Death	<u>JANUAR</u>		7 201 County of		1:48 P
	TALBOT HOSP	ICE HOUSE			EAS.	CON				LBOT		
	5. Social Security Number 220–48–0986	6. Sex 1 □ M 2 X F	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days		4 Hrs. Min.	8. Date of Bir (Month, Da 2-27-	ay, Year)		Counti	ace (State or Fore y) YORK
ě	Usual Residence of Deceder 10a. State 10b. C		10c. City,	Town or Loc	ation						10	d. Inside City Lim
Director	MD	TALBOT			E	ASTON						1 🗌 Yes 2 🕱
	10e. Street and Number				10f. Zip Code				10g. Ci	tizen of Wha	at Count	ry?
<u>-</u> -	26554 PRESQU			rer in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-							S.A.	
장 고	11. Marital Status1 ☐ Never Married 2 	Armed F	cedent Ever in U.S. Forces?	13. V	Yes, specify Cul	nispanic Origi pan, Mexican,	n? (Spec Puerto R	ity Yes or No- ican, etc.)		14. Race - Black, \	America White, e	
ב ב	3 Widowed 4 Div	If Voc G	live	1	☐ Yes 2 🗶 N	o Specify:				Specify:	w	HTTE
najaidilloo		ecedent's Education y highest grade complete	d)		ent's Usual Occi		of working	a	16b. K	and of Busin		-
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ωŀ	12 17. Father's Name (First, Mi	iddlo Last)	}		TEACH		1	//** 1 A # - 1 - 11 -	14-11-		DUCA	ATION
ا ۾		ANK SANGER				18. Mother	's Name	(First, Middle,		,		
-	19a. Informant's Name/Rela			19b. Mailin	g Address (Stree	1 t and Number	or Rural	AGNE Route Numbe			e. Zip Co	ode)
	ROBERT D. BOY	VI) 117	ISBAND		PRESQU							
	20a. Method of Disposition		20b. Pla	ce of Dispos	sition (Name of patory or other pl			ate		ocation - Ci		
ı	1 ☐ Burial 2 🛣 Crem 4 ☐ Donation 5 ☐ O	nation 3 🗌 Removal from Other <i>(Specify)</i>	m State CHES	APEAKI	CREMAT CENTER	'10N :	-30-2	2010	STR	VENSV	II.I.R	- MD
Ì	21. Signature of Funeral Se	ervida Liganska			L. P. IN 1 P. IN							,
		and the control of		22	Name and Add	one of Facility			TAM T	лись у	T 11/	ME PA
4	John M	11.		22 FE 20	TTALIC I	one of Facility	RTN	e neun	IAM I	TUNERA D 216	L H	OME, P.A.
+		4.	t caused the death.	FE 20	LLOWS, I	ess of Facility ELFENE RRISON	EIN ST.,	& NEWN EASTO	M, r	TUNERA D 216	101	Approximate
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DHMH 17 Rev 7/2009

State Registrar DAVID H. SMITH, MD 31. Date filed (Month, Day, Year) FEB 0 1 2010

8221 TEAL DRIVE, STE. 301, EASTON, MD 21601

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of rtificate of		ental Hy	giene		04617
	Physic	an	Decedent's Name (First, Middle, La	•				2. Date of D	eath Day	/ Year	3. Time of Death
	/Medi		MARGARET EDN					Feloru	any	02,201	
	Examir	ner	4a. Facility Name (If not institution, giv		122-6-1		or Location of Death			County of Deat	
			Brocke Grove Rehabili 5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year)			onen
	Funeral Director			M app F	86 Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D 10-19	nn ay, Year) 1 _ 1 Q	23 MD	hplace (State or Foreign untry)
			Usual Residence of Decedent	A				10-19	-192	ZJ MD	•
	how		10a. State 10b. County	VID-17	10c. City, Town or Lo						10d. Inside City Limits
	e Ma	cto	MD. MONTGO	MEKY	SAN	DY SPRI	LNGS				1X Yes 2 □ No
	or 20	Dire	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Co	untry?
	s 23e	rai		SCHOOL RO		208			U.S.		
	lter de	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🔀 N	Ever in U.S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Origin? (Spe pan, Mexican, Puerto I	cify Yes or N Rican, etc.)	0-	 Race - Ame Black, White 	
336	urs af	by	3 St Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2X No	Specify:			Specify: WH	ITE
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Items 23e or 28e-f show ite Medical Examinat must be notified at	Completed	15. Decedent's E		16a. Dece	dent's Usual Occu	pation		16b. Ki	nd of Business/	Industry
215	thin 7	ple	(Specify only highest gra	College (1-4or 5	life	DO NOT use retire	during most of worki ed)	ng	DES	MOINES	S REGISTER
	filed with Hygiene. other than	ပ်	1.2	2	OFF	ICE MAN			1		. BUREAU
Ē	be fil Ital H Id off	Be	17. Father's Name (First, Middle, Last, WILLIAM RAY.		TATO		18. Mother's Name				
1	2 should be 1 and Mental I is marked of raumatic eve	To					MARY AN				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumaits event. If a Medical Examinar must be notified at	1 8	19a. Informant's Name/Relationship (-	t and Number or Rura でしいなだり ロロ				
ම	Heal Heal tem 2		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	. D	ate	,	cation - City or	·
9	Pages ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		ST MARY	natory or other pla S CEMET	ERY 2-9-	2010			
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 tis any Injury or other tra ance.	1	21. Signature of Funeral Service Licer		79	2. Name and Addr	ess of Facility				•
ä	Depa Impo any Ir	5	Muhal			RAYMONE	FUNERAL A MARYLA	SERV	ICE,	P.A.	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not ent	er the mode of dy	ing, such as cardiac o	r respiratory a	arrest,		Approximate Interval Between
A.	Pnysician	i a	Immediate Cause (Final disease or condition	A 1	imer's d	isease					Onset and Death
	/Medical Examiner		resulting in death)		a consequence of):						years
	Lammer	_	Sequentially list conditions,	b							
	ted sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Dae to (of as a	я сопредыенся об.						
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	a consequence of);						
8760,	cate be exphysician the buria	dicai E		d							
9	tificate ig physi as the	ed		•							
Вох	leath certific attending p	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Ectopic pregnanc			1	23d. Date of deli	very
	ed for	sick	in the past 12 months? 1 □ Yes 2 XNo	4☐Pregnant at		Other (specify) _	·y			Month	Day Year
P.0	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	9 Unknown								
	signer bed	by	Part II. Other significant conditions of	ontributing to death bu	it not resulting in the u	nderlying cause gr	ven in Part I.				the cause of death?
Vital Records,	w requir	Completed	-						Yes 2	XNo 3 □ Pro	bbably 4 Unknown
3ec	has l	m d						24a. Was		24b. Were au prior to death?	topsy findings available completion of cause of
<u>=</u>			los Ma					1 ☐ Yes	2 No	1 Yes	2□ No
₹	Bici Oer rec	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Ot	26. Place of Death				
ō		-	27. Manner of Death	1 ☐ Inpatier 28a. Date of Injun (Month, Day		t 3□ DOA 28c. Inju	4 Nursing Hon	ne 5 Resi 8d. Describe			ufy)
Ö	Attending I r death. ector: After by the funer	ation	1 Accident 5 ☐ Pending investigation		Year) Injury		rk?]Yes 2 □No		,	,	
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ry - At home, farm, str	eet, factory, office	2	8f. Location ((Street and	d Number or Ru	ral Route Number,
	rs afte al Dir	Ceri		building, etc	. (Зреспу)			City or To	wn, State,	,	
	Hospital	cai	(Uneck only 2 Medical Exam	ysicien: To the best o	f my knowledge, death	occurred at the ti	ime, date and place, a	nd due to the	cause(s)	and manner as	stated.
	To the Hos within 24 h To the Fur completely	Medical	U.0,	and manner state	ted.						
	A S C S	- 1	29b. Signature and title of certifier	دا، ملام	م ما ما	29c. Licens	4			e signed (Month	
,			30. Name and address of person who	completed source of the	14 mys 12	174 J	7 65 74		V CO	Dy O	4,2010
			The state of the contract of t	van Lu.D.	ath (Item 23a) (Type,	Sel	rool fords	ando!	Soni	na Mou	2,2010 ford 2080
	Sta	te	31. Date filed (Month, Day, Year)		r's Signature	4				J	11000
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ames C. Baldwir		S 1- For State Registrar	tate of Maryla		artment of ertificate of		nd Mental	-	20 Reg. No.	10 04618
Physicia Medical Examin	n/	1. Decedent's Name (First, Midd	James Chri	stopher	Baldwi:	n		2. Date of De Month February	ath	3. Time of Death 1458 hrs
		4a. Facility Name (if not institution 108 Mincing Lane	on, give street and nu	mber)	Í	tb. City, Town, Elkton	or Location of De		4c. County of Cecil	Death
Funeral Director		5. Social Security Number 215-11-8083	6. Sex 1 M 2 F	7. Age (In yrs. 23	last birthday) Yrs.	If Under 1 Ye Months Da		/lin.	1/1986	9. Birthplace (State or Foreign Maryland Country)
v any		Usual Residence of Decedent 10a. State 10b. County			y, Town or Locati				1/1900 [10d. Inside City Limits
n the Maryland 3a or 28a-f show officed at once.	rector	Maryland Cect 10e. Street and Number	<u>i1</u>	E1	kton	10f. Zip Code	_	T	10g. Citizen of Wha	1 Yes 2 No
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral Director	108 Mincing La 11. Marital Status 1 X Never Married 2 M	12. Was Dece Armed Fo 1 Yes	2 X No	If Ye	es, specify Cub	lispanic Origin? (an, Mexican, Pue	Specify Yes or N rto Rican, etc.)	O- United O- 14. Race - White,	American Indian, Black,
7 .	eted by	3 Widowed 4 Div 15 Decedent's Education (Spe Elementary/Secondary (0-12)		le completed)	16a. Decedent		lo s <i>pecify:</i> ation (Give kind of fe. DO NOT use r		Specify:	White ness/Industry
	Be Completed	12 17. Father's Name (First, Middle, James Roy Balo	•		Fra	mer		me (First, Middle,	Maiden Surname)	ruction
MD 2121: d 2 should be fil tht and Mental Is n 27 is marked aumatic event,	<u></u>	19a. Informant's Name/Relations Kay E. Down/G	ship (Type, Print)		108 M	incing	eet and Number of		mber, City or Town, 21921	
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If item 27 is re injury or other tranmatic		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Sp	pecify:	om State Imi	Place of Disposice crematory or oth TIACULATE	er place) Concep	tion Fel	oruary , 2010	20c. Location - C	v Hill. MD
Balt Departing Import	1	21. Signature of Funeral Service 23a. Part I. Enter the disease, or	S tuck complications that ca	use the death	22. Na Hic 1103	ame and Addres ks Home W. Sto e mode of dving	ss of Facility E for Fur Ockton St D. such as cardiac	nerals, I	P.A. 1kton MD	21921 Approximate Interval
/Medical Examiner		failure. List only one cause Immediate Cause (Final diseas) or condition resulting in death)	on each line.	hydromo	rphone,		one, and			Between Onset and Death
led Insit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a control of the c							
be executivities in and and unial - tra		X UNPENDED	d AMENDED	Ba.PII.	27 . 28a-1	f.permE	. g901 3	/16/10 T	<u> </u>	
Box 6876(death certificate the attending physel for use as the boxeinian/Me	2	F FEMALE: 3b. Was decedent pregnant in th past 12 months? 1 Yes 2 No 9 Unk	1 Live bir	rth int at time of de	2 Feta	al death 3 er (Specify)			23d. Date of de Month	livery Day Year
ires that the designed by the a detached for the detached	Š	Part II. Other significant conditi Hypercoagula						23e. Did to		te to the cause of death? Probably 4 Unknown
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of Vitaling Physician: After this certit Uneral director	200	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 In	patient 2 finjury	ER/Outpatient 28b. Time of Inj	3 DOA	of Death (Check Other Nurs ury at Work?	ing Home 5	Residence 6 🗸 0	Other: Scene
Division of Vital Records, P.O. Box 6876(e Hospital or Attending Physician: The law requires that the death certificate 1.24 hours after death. 1.24 hours after death. 1.24 hours after death. 1.24 hours after death. 1.25 hours after death. 1.25 hours as the therefore the content of the strending physician for the formal director, page 2 should be detached for use as the the content of the con		3 Suicide 6 Could 4 Homicide deten	ing tigation 2/6/1	10	unk ome, farm, street,		Yes 2 X No building, etc.	narcoti	c medicat Street and Number o	
To the Hos within 24 h To the Fun completely			nysician: To the best miner:On the basis of and manner sta	examination a						
	2	9b. Signature and title of certifier				29c. Licens			29d. Date signed February 7, 2	
<u>_</u>			istant Medical Ex	xaminer	111 Penn Sti	reet, Baltime	ore, MD 2120)1		
State Registra		1 Date filed (Month, Day, Year)	1 9 2010	istrar's Signatu	re B. A	Barre				

State Registrar

31. Date filled (Month, Day, Year) FEB 19 2010

Rana

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30MO

29b. Signature and title of certifier



DHMH 17 Rev 1/2001

29c. License number

STREET

29d. Date signed (Month, Day, Year)

PALTIMORE MD

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nysician/Me	IF FEMALE: 23b. Was dece in the past 1 ☐ Yes 9 ☐ Unkno
by PI	Part II. Other si
Completed	
ro Be	25. Was case re examiner? 1 ☐ Yes
Certification:	27. Manner of □ 1 Natural 2 □ Accider 3 □ Suicide 4 □ Homicid
cal	29a. Certifier (Check only

23e. Did tobacco use contribute to the cause of death? gnificant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 ☐ Yes eferred to medical 26. Place of Death (Check only one Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 □No ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifie 29c. License number

3 Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No

30. Name and address of person eted cause of death (Item 23a) (Type, Print)

Year)

32. Registrar's Signature

State Registrar

DIC

24 hours a

within 2 To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edna February 6. 2010 ar Baer 4:45 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Citizens Care & Rehabilitation Center Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**□ F Mary Land **Director** 214-28-5621 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Frederick Frederick 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5035 Old Swimming Pool Rd. 21703 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. Completed Specify: white 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) child care caregiver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be f Department of Health and Mental Important: If item Z7 is marked any injury or other traumatic ev any injury or other traumatic ev once. ٥ Goldie P. Baugher James L. Schultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Villalva / sister P.O. Box 1722 Roanoke, VA. 24008 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗶 Burial 2 □ Cremation 3 □ Removal from State 2/13/2010 Mt. Olivet Cemetery Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Keeney and Bastord PA Funeral Home 106 East Church St., Frederick, MD 21701 MO1222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CONGESTIVE Physician/ HEART FATLURE disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Toknown cate has been signated by page 2 should by Completed DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 HNo Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA eral Director; After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie DOO 61410 FEB, 8, 2010 MD

State Registrar 7011

FLOUSE - HY FREDERICK, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day

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		•	For State Registrar		State of iv	iaryiai		rtifica:			ivientai my	Reg. N	20	10	04	622
	Physicia	n/	1. Decedent's Name Barbara		•						2. Date of Do Month		ay 7 .	Year	3. Time o	
	Medic Examine	or	4a. Facility Name (if n	not institution, giv	re street and number)			4b. City	, Town, or	Location of Deat		-4	c. County	of Death	1	
	Francis	Ц	Upper Ch Medical 5. Social Security Nur	esapea <u>Center</u> mber 16	Ke Sex 7. A	ne (In vrs.	last birthday)		Ai er 1 Year	r If Under 24 Hrs	8. Date of Bi	irth	Har		place (State	or Foreian
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	show dat	tor	Usual Residence of D 10a. State	10b. County		10c. Ci	ty, Town or L	ocation	_						10d. Inside C	
	r 28a-f	Director	Maryland 10e. Street and Numb	Harf	ord		White		D Code			10a C	Citizen of N	What Co.		s 2 💢 No
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336	b o o o o o o o o o o o o o o o o o o o										ck, White,	etc.				
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and	oe filed antal Hy ked oth c event	_	17. Father's Name (Fit Jessie O								me <i>(First, Middle</i> or Mie]		n Surnam	e)		
i 801 1 Maryland	should be file and Mental is marked c raumatic eve		19a. Informant's Nan				1			and Number or Ru						
	and 2 s Health tem 27		James F.		/Husband	20h.	484 (Road Wh					. 6 1 Town, State	
7.0.5 Baltimore,				Cremation 3	\mathbf{X} Removal from Stat	e Cre	emetery, creematic	matory or On D	other place irec ce	Feb 2	.Date 7,	1	rk,	-		
Balti	permit. Page Department of Important: If any injury or once,		21. Signature of Fune	eral Service Lice	nsee		2	22. Name a	nd Addres	ss of Facility J. Main S						
			23a. Part 1. Enter the	e disease, or con	mplications that cause one cause on each li	ed the dea							wai	0.5 00	Approxima Interval Be	ite
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7	Examiner		,	ſ	Due to (or as	•	quence of):								Zda	ius
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(g) 80	ate be o	edical		•	a. 5+a=	0 4	4 Ce	-CV	cal	Can	cer				24	ears
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יסכו	Hospit 24 hour Funera rted fille	Medical	(Check 2	Medical Exa	nysician: To the best ominer: On the basis of	examination	on and/or inve	stigation, in	n my opinio	on, death occurred	l at the time, date	and place	ce, and du	e to the c	ause(s) and m	anner stated.
80	To the I within 2 To the I comple	Ĕ	only one) 3 [29b. Signature and ti		urse Practioner: To th	e best of n	ny knowledge		urred at the		lace, and due to t				stated. , Day, Year)	
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	154		deffra	en A	completed cause of	death (Ite	m 23a) (Type,	Print)	50¢	el A	- Ches	ap	la	Q of	10 ci	e 14
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Phyllis C. Bowman Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Reg. Med. Center Cumberland Allegany 5. Social Security Numbe 8. Date of Birth
(Month, Day, Year)
Nov. 3, 1941 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 👿 F Months Days Hours Min. Director Hutton, 234-68-4791 68 Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits WV Mineral 1 Yes 2 X No Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Rt. 5, Box 314 26726 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural", 3 Widowed 4 Divorced Specify: White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Cook Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Joseph Earl Gank Edna Mae Wilmoth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Michael R. Bowman/Husband Rt. 5, Box 314 Keyser, WV 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Queen's Point Cemetery Keyser, WV Signature of Funeral Service 22. Name and Address of Facility Smith Funeral Home Men 85 S. Main Street Keyser, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) in. 22 Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine If any, leading to immedia cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Day 1 Yes 2 been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performe death? ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury Accident Investigation 1 Tes 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certif 29c. License number 06033280 Jes 5,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunil Gupta, M.D. 625 Kent Avenue Cumberland, MD 21502 31. Date filed Mon 82. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 2 State of Maryland a Department of Health and Mental Hygiene | State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ GROVER 20 M CORNELIUS BROADWATER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Western MD Regional Medical Center Cumberland Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 **X** M 2 □ Min 90 0470171919 Maryland Director 214-12-3406 Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director MD Allegany 1 Yes 2 X No LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ll Macy Drive 21502 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b Kind of Business Industry ield (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Tire Company Tire Builder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harman Grover Broadwater other traumatic Harriett Catherine Bittinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Broadwater / Son 330 <u>Kitchen Orchard Rd, Hedgesville, WV 25427</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Restlawn Meml.Gardens 02/04/2010 injury (4 ☐ Donation 5 ☐ Other (Specify) LaVale, MD 21. Signature of Funeral Service Licensee Name and Address of Facility Hafer Funeral Service, P.A. exchurch 1302 National Highway, LaVale, 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Inter al Between On and Death Immediate Cause (Final Physician, rosepsis disease or condition resulting in death) Medical Due to (or as a cons quence of): Examiner Complications of Left Shoulder Fracture Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death ate has been signed by the a page 2 should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2. No After this certificate 1 Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 220 100 Certificate: To 14 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 01/28/2010 $\textbf{Unknown} \; \mathsf{M}$ 1 ☐ Yes 2X No Investigation Subject fell. Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1262 Vocke Road, LaVale, MD 4 Homicide determined Mall Parking Lot To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my printing death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DG0 3328c 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunil Gupta, M.D., 625 Kent Avenue, Cumberland, MD 21502 31. Date filed (Month, Day Year) 2010 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For 2-2-10
Registrar Amend#'s28a.b.c.d.&f.Per ME. Porcer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan. 20°, 20°° 19:05 P M Evelyn Maria Brooks Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Narch 25, 1946 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Birthpiec Country) DC **Funeral** 1 🗆 M 2 🖾 F Months Davs Hours Min. 577-64-3167 Director March Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Department of Health and Mental Hygiene. Important: if items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. once. Director 1 🔀 Yes 2 □ No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? $\beta \cos kes$, E velyeBaltimore, Maryland 21215-0036 Funeral 103 G Street SW 20024 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc þ 1 Never Married 2 X Married Specify: African 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed American Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Government Administrative Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charolotte Berry Edward Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington, DC 1116 Eastern Ave. NE Steven Brooks/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗌 Burial 2 🔀 Cremation 3 🗍 Removal from State February Lee's Crematory 4 Donation 5 Other (Specify) 2010 Clinton, Maryland 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Fund al Service Licer 20019 Washington, DC 4001 Benning Rd. NE 23a. Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock. The heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Chaking / U.
Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine n any, leading to introduce cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth
Pregnant
Unknown in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed vascular disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has ral director, page 2 a autopsy death' 1 Yes 2 No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 XYes 2 □ No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 မ 4 Nursing Home 5 Residence 6 Other (Specify DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Jan. 20, 10 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1700 Natural 5 Pending work? 1 ☐ Yes 2 🔀 No 2 Accident 3 Suicide choking on food Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 4922 Lasalle Rd. Hyattsville, NUTSING Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and titl 29c. License number 29d. Date signed (Mooth, Day, Year) 7010 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) F.A.C.S. 2101 Medical Park Dr. Suite 304 Silver Spring, MD Besty Ballard, M.D., State FEB 0 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	ate of Marylan		artment of F rtificate of			giene Reg. No.2010	04626
Physic	ian	1. Decedent's Name (First, Middle, Last) Clara Olivia Baldwi	n				2. Date of Dea Month JANUAF		3. Time of Death 2:30A.M.
/Med Exami		4a. Facility Name (If not institution, give street			4b. City, Town, o	r Location of Dea		4c. County of Deat	
- V		Reeders Memorial Nu	rsing Home			sboro		Washingt	
Funera Directo		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. I	la <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		y, Year) Co	hplace <i>(State or Foreign</i> untry) e rdale, MD
and w		Usual Residence of Decedent 10a. State 10b. County	10c City	y, Town or Lo	cation)		10d. Inside City Limits
Maryla 1 sho	Ď	Maryland Washington		harpsb					1 ☐ Yes 2 📉 No
r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
th wit 23a c	ral	2404 Dargan School	Road		2	21782		USA	1
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evaluation must be notified at once.	by Funeral Director	1 Never Married 2 Married	as Decedent Ever in U. med Forces? _Yes 2 X No /es, Give ar or Dates:		Was Decedent of H If Yes, specify Cub 1 □ Yes 2 🏻 No		Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
within 72 hours affiliene: than "natural", or	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	pleted) pllege (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most of we	orking	16b. Kind of Business/ Own Home	Industry
d Z I Z I; filed within 7 Hygiene. other than "r ent, I we		8		Home	emaker	10. Mathava Na	rme /First Middle	,	
Maryland 2.12 nd 2 should be filed within ulth and Mental Hygiene. 27 is marked other than r traumatic event, I.M.	To Be	17. Father's Name (First, Middle, Last) Charles Lamont					_{ame (First, Middle,} ce Taylor	Maiden Surname)	
VICELY ICE 12 Should The and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type. Pr						er, City or Town, State, 2	
t and 2 Health tem 27 i	-	Clara E. Chaney / D			sition (Name of matory or other place		Date Date	20c. Location - City or	
Pages ent of nt: If ii		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	ai irom State		natory or other pla In Cemeter	1 0 / 1	1/2010	Brentwood,	Maryland
Baltimore, permit. Pages 1 an Department of Hea Important: If item; any injury or other once.		21. Signature of Funeral Service Licensee	man	22	2. Name and Addre	ess of Facility	I		lmore Avenue
Physician	_	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau immediate Cause (Final disease or condition resulting in death)	se on each line.	Do not ent		ng, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death 5-10 mm
/Medical Examiner			Due to (or as a consequence of the consequence of t		FIBRIL	LATION			YEARS
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he death certifiing the attending I shed for use as	Physician/Medical	in the past 12 months?	yes, outcome of pregna □ Live birth 2 □ Fetal □ Pregnant at time of d □ Unknown	Ideath 3	☐Ectopic pregnand ☐Other <i>(specify)</i> _	су		23d. Date of del Month	ivery Day Year
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The law requires to cate has been signed page 2 should be cate	Completed						24a. Was autop perfo 1 □Yes	osy prior to rmed? death?	itopsy findings available completion of cause of 2 Drivo
Physician: The rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	11.		oth oth		eath (Check only o		
Phys r this	n: To	27. Manner of De th 28	a. Date of Injury (Month, Day, Year)	28b. Time o Injury	II 3 LI DOA	4 Mursing		dence 6 Other (Spe	cify)
I or Attending Physician: after death. Director: After this certifice din by the funeral director,	Certification:	1 No Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 286	e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	M 1 □	lYes 2□No	28f. Location (S	Street and Number or Ro vn, State)	ural Route Number,
Hospita 4 hours Funeral tely filled	Medical Ce	(Check only 2 Medical Examiner: C						cause(s) and manner a date and place, and due	
To the within 2 To the complete	Be	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mont	h, Day, Year)
		Maleda /	mo		D	46561		JAN 28	, 2010
021		30. Name and address of person who complet	,		,	2020 112	DVI TND C	1710 201 4	22 0470
	ate	DR. GHAZALA QADIR. 2 31. Date filed (Month, Day, Year)	0311. LAPPA 32. Registrar's Signe	NS ROA	D, BOONSI	BORO, MA	RYLAND 2	1/13 301-4	32-8470
Regis		FFR 0 2 2010 Serve	1 1 d. 1	artes					

DHMH 17 Rev 1/2001

Box 68760 P.O. Records, **Division of Vital** within 24 hours after death

To the Funeral Director: of the completed filled in by the

State Registrar

Paul A. Silver, M.D. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier (Check

only one)

29b. Signature and title of certifier

JAN 2 **9 2010**

2150 Pennsylvania Avenue, N.W.; Washington, D.C. 20037 32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0040102

29d. Date signed (Month. Dav. Year)

2010

January

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Genevieve Brown 27 2010 10:10 P Jan. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Prince Georges Fort Washington Nursing and Rehab. Fort Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Days Hours 1 □ M 2 ☑ F 21, 231-34-7142 93 Jan. 1917 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Prince Georges Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12021 Livingston Road 20744 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Black 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 D. C. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Johnson Emma Muse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5511 Gunshot Pass Drive, Colorado Springs, C: 80917 James Brown - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 2/3/2010 Brentwood, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Bell and Johnson Funeral Home, P. A. 6503 Old Branch Ave., Temple Hills, MD 20748 23a. Farth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) heroscle Dut to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last con equence Due to (or as Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Hriknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy 2 No 1□ Yes 26. Place of Death (Check only one) Other: All Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 Inpatient 2 ER/Outpatient

Physician /Medical Examiner

that the death certificate be executed

Box 68760.

P.O.

Records,

Division or Vital

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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23a

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Department of Health Important: If Item 27 any injury or other tr once.

Pages 1 ment of F

s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the Me

Director

Funeral

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Completed

Be

death with the Maryland

filed within 72 hours after

Maryland 21215-0036

Baltimore,

Examiner burialphysician at the burial Physician/Medical nse for ed by the a signed b Completed by page 2 certificate has Be Certification: To this funeral After thin 24 hours after death.

the Funeral Director: After the function by the function of the fu

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury **₩** Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24

Hospital or Attending

the

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

701

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JAMES FRANKLIN BLUNT 1/22/2010 031/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Hours Min (Month, Day, Year 8/19/1949 1 1 M 2 D F Director Washington. 577-64-8181 60 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1613 Newton Street NE 20018 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give þ 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Black Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Printer Government Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Isaac Blunt Millie Bell Giles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmen Blunt / Wife 1613 Newton Street NE Washington, DC 20018 item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 ₺ Burial 2 ☐ Cremation 3 ☐ ₽ moval from State cemetery, crematory or other place 4 Donation 5 Other (Special Lincoln Memorial 1/30/2010 Suitland, Maryland 21. Signature of Funeral Se 22. Name and Address of FacilityPope Funeral Homes, P.A. 40108 5538 Marlboro Pike Forestville, Maryland Inter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ RESPIRATORY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** MORBID OBESITY Sequentially list conditions cause. Enter Underlying Exami attending physician هنام for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events RENAL CELL CARCINOMA Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Year Month Pregnant at time of death]Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, CARDIAC DISEASE 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an SEPSIS autons page 1 ☐ Yes 2 🛣 No ☐ Yes 2 🕱 No Division of Vital Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tyes 2X No ျ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pendina 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined 24 hours a Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопріете 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practionar: To the less of my knowledge of extra control of the cause of the within 7 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) D62171 1/23/2010

State Registrar

1500 Forest Glenn Road Silver Spring, Maryland 20910

30. Name and address of person who completed cause of leath (Item 23a) (Type, Print)

Ashish Behari

Day, Year

JAN 29

10-00758 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 04630 Douglas Brown State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day January 26, 2010 Medical Examiner ouglas ransawn 0341 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYYY) 9. Birthplace (State or **Funeral** Foreign Director Months Hours 578-60-9947 63 CountryWash. 1 X M 01/09/1947 Yrs Usual Residence of Decedent any 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once. Yes 2 No Washington. ges I and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene.

If item 27 is marked other than "natural", or items 73a or 73a, ctack Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3363 63rd St. NE 20019 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, "natural", or items | Examiner must be Armed Forces? 1 Never Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 2 Married 2 X No Yes 1 Yes 2 No specify: Black 3 Widowed Divorced If Yes, Give Year Specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) tem 27 is marked other than " traumatic event, the Medical Baltimore, MD 21215-0036 12th Home Improvement 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Charles Brown Fannie Mae Love 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 2007 47 19a. Informant's Name/Relationship (Type, Print) Jewel Brown/ Spouse 5517 Marlboro Pike Apt#15 District Hts.MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 🔀 Burial 2 Cremation 3 Removal from State Heritage Cemetery Feb. 9, Donation 5 Other Specify 2010 Waldorf, MD 22. Name and Address of Facility Pridgen Funeral Service 21. Signature of Funeral Service License uawana 9013 Annapolis Rd. Lanham 20706 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Hypertensive atherosclerotic cardiovascular disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical X UNPENDED signed by the attending physician be detached for use as the burial AMENDED 23a,27,permE, g900 g899 2/22/10 TT Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been s'ector, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed Yes 2 ✔ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 this Residence 6 Other 1 Yes 2 No After 28a Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural neral Director: filled in by the f death. Pending 1 Yes 2 No Accident 24 hours after de Funeral Direc 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 27, 2010 buthall, mi 30. Name(and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year)
FEB 0 5 2010 32. Registrar Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	artment of Health and N rtificate of Death		ene g. No 2010 04631
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Janice Jean Benson		2. Date of Death Month January	25, 2010 3. Time of Death 6:00 P M
	Examin	er	4a. Facility Name (if not institution, give street and number) 2408 Sheridan Street	4b. City, Town, or Location of Death Hyattsville		4c. County of Death Prince George's
	Funeral Director		5. Social Security Number 214-70-4115 G. Sex 7. Age (In yrs. last birthday) 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8, Date of Birth (Month, Day, Y November 2	9. Birthplace (State or Foreign Country) Takoma Park, MD
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10a. State 10b. County 10c. City, Town or Li Maryland Prince George's Hyatts 10e. Street and Number			10d. Inside City Limits 1 ☑ Yes 2 ☐ No Og. Citizen of What Country?
	th with th ms 23a o must be	Funeral	2408 Sheridan Street	20782		USA
9800	urs after dea tural", or ite al Examiner	ted by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Veser Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within 72 ho giene. ier than "nai i, the Medica	Completed by	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired) es Representative	king	6b. Kind of Business Industry Sales
yland	ld be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Emil John Milasuk	18. Mother's Nam Bettie	ne (First, Middle, Ma Conklin	aiden Surname)
	nd 2 shou ealth and m 27 is m		Nancy Janet Downs / Sister 7 Gr	ing Address (Street and Number or Rur egoria Court, Bal		
Baltimore,	Page 1 ament of H			matoni or other place)		Alexandria, Virginia
Balt	permit Depart Import any inj			2. Name and Address of Facility asch's Funeral Hor		4739 Baltimore Avenue Hyattsville, MD 20781
	h, sician/ Medical Examiner	er	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, b.		or respiratory arres	t, Approximate Interval Between Onset and Death
094	Hospital or Attending Physician: The law requires that the death certificate be executed thours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to financiate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):			
). Box 687	t the death certifical by the attending ph tached for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
ds, P.O.	requires that been signed k should be deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the cause of death? s 2 🖾 No 3 🗆 Probably 4 🗀 Unknown
Recor	: The law requi cate has been ; page 2 shouli	Completed by			24a. Was an autopsy perform	ned? death?
f Vital	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time of Death		ome 5 🛛 Resider	nce 6 Other (Specify)
Division of Vital Records,	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Certificate:	1 X Natural 5 Pending 1 Accident Investigation 3 Suicide 4 Homicide determined (Month, Day, Year) 1 X Natural 5 Pending (Month, Day, Year) 1 Natural 5 Pending (Month, Day, Year) 1 Natural 5 Pending (Month, Day, Year) 28a. Place of Injury - At home, farm, st building, etc. (Specify)	work? M 1 ☐ Yes 2 ☐ No	28d. Describe how 28f. Location (Stre City or Town,	eet and Number or Rural Route Number,
	Hospital 24 hours a Funeral D	Medical (29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inve	stigation, in my opinion, death occurred a	at the time, date and	place, and due to the cause(s) and manner stated
	To the I within 2 To the I complex	Σ	only one) 3 Certifying Nurse Practioner: To the best of my knowledge. 29b. Signature and title of certifier	29c, License number D64983	T T	ause(s) and manner as stated. Id. Date signed (Month, Day, Year) 1/26/2010
1	26		30. Name and address of person who completed cause of death (Item 23a) (Type, Kashif Alam Firozvi, 2101 Medical H		#200, Silv	ver Spring, MD 20902
	Sta Registr		JAN 2 8 2010 Security 32. Registrar's Signature	<u> </u>		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND31, See32,72/4/10EMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 2, 2010 Physician/ Inez Beyda 6:30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 🏝 F Hours Min. Months Sep 23, Haiti Director 577-48-9295 95 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County other traumatic event, the Medical Examiner must be notified at Director or items 23a or 28a-1 1 Yes 2 No MD Montgomery Chevy Chase 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4701 Willard Avenue #1634 20815 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify "natural" Specify: 3 ☑ Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important; if item 27 is marked other than any injury or other traumatic manner. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Children's Apparel Retail Merchant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Bijou Rache1 Sitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001619a. Informant's Name/Relationship (Type, Print) Richard Beyda/Son 4853 Rockwood Parkway, N.W., Washington, D.C. 20b. Place of Disposition (Name of B nanter) gratering contact Conference Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 2/3/2010 Oxon Hill, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Melissa C59 Greenhut 22. Name and Address of FEG ward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pneumonia Physician Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 4 Pregnant at time of death 1 Yes 2 No been signed by the should be detached g
Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🗌 No 3 🗌 Probably 4 🏝 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 🗌 Yes 2 🔀 No 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 XInpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 🛣 Natural 1 Yes 2 🗌 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sujoy Tagore, MD 8600 Old Georgetown Road Bethesda, Maryland 20814

DHMH 17 Rev 7/2009

State Registrar Year) 2010

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Edward Michael		er St 1- For State Registrar	ate of Maryla		artment of rtificate of		Mental H		20 l	0 04633		
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medicai Exami	IICI		(ichael Baer not institution, give street and number) 4b. City, Town, or Location					January 20, 2010				
		Shady Grove Adventi	st Hospital			Rockville			Montgome	•		
Funeral Director		5. Social Security Number 217-60-5418		7, Age (In yrs. I	last birthday)	If Under 1 Year Months Days	If Under 24Hrs Hours Min	s. 8. Date of Bi	rth(MM/DD/YYYY)	9. Birthplace (State or Foreign DISTICT		
Director		Usual Residence of Decedent	1 M 2 F	44	Yrs			Jan. 6	,1966	countre Stumbia		
any		10a. State 10b. County			, Town or Locati		-			10d. Inside City Limits		
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	1	20a. Method of Disposition 1 Burial 2 X Cremation	2 D D			ition (Name of cem-	etery,	Date	20c. Location - C	ity or Town, State		
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Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr	1	21 Signature of Funeral Service	Licensee		22. N	ame and Address	of Facility 101	uglas A	. Fiery F	uneral Home		
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/Medical	1 2	failure List only one cause Immediate Cause (Final disease	S. H IAS at Land Landson	ries						Between Onset and Death		
Examiner		or condition resulting in death)	Due to (or as a		rf):							
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3760 ficate g phys s the bu	Me	IF FEMALE: 23b. Was decedent pregnant in the		utcome of preg		al death 3	Ectopic pregna	ancy	23d. Date of de Month	elivery Day Year		
Ox 6876(eath certificate attending phy.	icia	past 12 months?	4 Pregna	int at time of de	ath -	ner (Specify)		anoy	Working	Day Four		
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Divis To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	_	29a. Centrier										
To the within 7 To the complet	Medica	29b. Signature and title of certifie	and manner sta			29c. License				(Month, Day, Year)		
		Jours h 9	ithall Mi)		O.C.M	l.E.		January 27, 2	2010		
	l	30. Name and address of person		-	·							
5H-5		Pamela E. Southall, N		ledical Exa estrar's Signatu		Penn Street,	Baltimore, I	VID 21201				
St Regist	ate rar	31. Date filed (Month, Day, Year)	2010	rstrar's Signatu		del						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 04634 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Thomas Carroll Bader, Sr. 11-56 A M January 2010 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Sinai Mospetal Baltimore an 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. Ju**Y**Y^{th,}**P8^{y, Yea}Y**919 90 218-03-5199 **Director** Maryland Usual Residence of Decedent 28a-f show 10b. County "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😾 No Maryland Carroll Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. 1714 Bethel Rd. USA 21048 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1

Yes 2 □ No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2X No Specify: WII Specify: White 3 ₩ Widowed 4 □ Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Builder Construction Be 17. Father's Name (First, Middle, Last) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) Thomas George John Bader Ella Shane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard G. Bader/Son 1915 Bethel Rd., Finksburg, MD 21048 or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) arroll Cremation Inc. Feb 8,2010 Hampstead, Maryland any in 21. Signature of Funeral Service Lice Printed After Fally Home and Chapel, P.A. 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that outside the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final emplete heart Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner days ute myocardial Successfields list recolling Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Year Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed?/ Yes 2 No this certificate has 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation after death Director: the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by determined City or Town, State) 24 hours a Funeral I Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier Ö 29c. License number 29d, Date signed (Month, Day, Year) RES-000 26,2010 Batimore 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) illai MD Sina

State Registrar 31. Date filed (Month, Day, Year)

JAN 28

egistrar's Signature

Box 68760. P.0. Division of Vital Records. Hospital or Attending Physician: completely filled in by the funeral director. after death. 24 hours a

SEMS+1 State

PHILIP WISOTSKY, M.D. 31. Date filed (Month, Day, Year) FEB U 3 2010

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

29c. License numbe

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

FEBRUARY 2, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

6 ☐ Could not be

determined

12070 OLD LINE CENTER, SUITE 207, WALDORF, MARYLAND 20602

32. Registrar's Signature Leneusa

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 01/24/2010 **Physician** 1:05 p M Crockett Elizabeth Jane /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner McCready Memorial Hospital Crisfield
If Under 1 Year I If Under 24 Hrs. Somerset 9. Birthplace (State or Foreign Country) Virginia last birthday) Date of Birth 09/72/1926 **Funeral** 220-24-7102 83 Days 1 ☐ M 2 🛛 F Yrs Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene.

arked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Tangier VA **Funeral Director** Accomack 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 16663 West Ridge Road, 23440 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: NO Yes 2**⊠**No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Teachers Aide Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be f Health and Menta Item 27 is marked Willie C. Crockett, Sr. Nina Landon ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any Injury or other traum once. P.O. Box 86, Tangier, VA 23440 Howard Douglas Crockett(husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Crockett Cemetery 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Tangier, Virginia 01/29/2010 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 25046 Parksley Road J. Willams 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Parksley, VA 23421 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician the as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 I Inknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s. autopsy performed certificate 1 Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) JAN28

· YIJAY

KARUMBUNATHAN

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

2010

HALLHIGHWAY, CRISFIELD, MD, 21817

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2055 P VIOLA C. CLARK 1 30 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner CALVERT MANOR HEALTHCARE CENTER RISING SUN CECIL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth 10-19-1912 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min. 1 □ M 2 😾 F 222-52-4543 97 DELAWARE Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f sl other traumatic event, the "Model Examiner must be nutilied Director 1XYes 2 □ No MARYLAND HARFORD BEL AIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1937 THOMAS RUN CIRCLE 21015 US permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medial Examination ust Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2X No Specify: WHITE δ Specify: 3K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ARCHIE FRANK SAVAGE GRETCHEN WAINWRIGHT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) KAREN KENNEDY/DAUGHTER 1937 THOMAS RUN CIRCLE, BEL AIR, MD. 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State ST. GEORGE'S CEMTERY 2/5/2010 4 ☐ Donation 5 ☐ Other (Specify) CLARKSVILLE, DELAWARE 21. Signature of Fune al Service Line es MELSON FUNERAL SERVICES, LTD THATCHER STREET, FRANKFORD, DE. 19945 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or con ition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery lor. 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) ned by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Medical Certification: To 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

State Registrar

completely

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 33a) (Type, Print

FEB 0 4 2010

PNDO

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 2010 February Bertha Frances Coleman 12:55 p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Envoy of Denton Denton Caroline If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Jan 23 1933 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F Yrs 139-26-7630 New Jersey Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 X No Director Delaware Kent Harrington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or r must be r 133 Jenny Lane 19952 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. "natural", or items 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No White Specify: Completed by 3 ☐ Widowed 4 🖾 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) mobile home industry manager permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important: If Item 27 Is marked other any injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fred William Hawkins Sara Frances Flitcraft 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William R. Coleman/ 19952 133 Jenny Lane; Harrington, Delaware 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb 15 2010 1 Burial 2 □ Cremation 3 □ Removal from State Pittsgrove Presbyterian Cemetery 4 Donation 5 Dother (Specify) Elmer, New Jersey 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA PO Box 160; Greensboro, MD 21639 23a. Part! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pirahon oneumones /Medical Due to (or as a consequence of): Examiner DEI Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month for Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 TYes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 certificate 1∐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation Injury 1 Natura thours after death.

uneral Director; Afely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only one) 24 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0047534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 920 Market Street; Denton, MD 21629 Wafik Zaki, MD;

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 12

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2010 Sr. February 7:05 A M John Norris Coulby, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Talbot Hospice House Easton If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 99 Director October 5, 1910 Maryland 220-32-0414 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show Director 1 ¥Yes 2 ☐ No Talbot Easton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 29299 Heworth Road 21601 2 should be filed within 72 hours after death v and Mental Hygiene. Is marked other than "natural", or Items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 👿 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. \$ 3 Widowed 4 Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Merchant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked, any injury or other traumatte ev. once. Mary Louise Norris John Howard Coulby ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29299 Heworth Road, Easton, Maryland Edna Coulby Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Junior Order Cemetery 2/12/2010 4 Donation 5 Other (Specify) Preston, Maryland ettine of Funeral Service Lice 22. Name and Address of Facility Moore Funeral Home, P.A. 21629 12 South Second Street, Denton, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstructive **Physician** disease or condition resulting in death) Wars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit the death certificate be executed Exami Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the ned by the attending produced as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, eral Director: After this certificate if the funeral director, pag Hospital or Attending Physician: within 24 hours a To the Funeral C To the

DHMH 17 Rev 1/200

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

Registrar's Signatur

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Deficiently medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #11, per Fh g901 3/17/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month LARRY FRANKLIN CELEY Fehruary Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth May 21, 1945 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Mary Land Director 215-44-3281 64 Usual Residence of Decedent f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No Washington Maryland Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1219 Grand Legacy Drive 21740 United States Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces 1 Never Married 2 X Married ò 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: "natural", 3 ☐ Widowed + ₩ Dive Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Executive Officer Printing Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Floyd Maxton Celey Gwendolyn Elvidge Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 st ment of Health a ant: If item 27 is Max Celey / Son 2618 North Oakland Ave. #12, Milwaukee, WI 53211 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 KCremation 3 Removal from State permit. Page Department of Important: If any Injury or Resthaven Crematory 4 Donation 5 Other (Specify) Feb. 2, 2010 Frederick, Maryland 21. Signature of F Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease, shock, or heart failure, Lis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician hemor Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a co physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Medical death certificate be Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) Yes 2 No ed by the a 9 Unknown 9 Unknown P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 1 Yes within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\triangle \) Nursing Home 5 \(\triangle \) Residence 6 \(\triangle \) Other (Specify) 2 No 1 \sum Yes ည 1 🗖 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d, Describe how injury occurred 1 Natural work? 1 🗌 Yes 2 🗆 No injury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 2010 MDD 35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 400 West 7th Street, Frederick, MD 21701 Myung Hee Nam, 10 31. Date filed (Month, Day Year) 32. Registrar's Signature State ark Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JXW. KATHLEEN ANN CARLIN 29 2010 21:50PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST ROCKVILLE MONTGOMERY HOSPITAL Social Security Number If Under 1 Year If Under 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Funeral Year) 1<u>948</u> Months Days Hours Min. (Month, Day, YOCT 10 Director 218-52-9043 61 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MONTGOMERY 1 Yes 2 No GERMANTOWN MD 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 20016 WANEGARDEN COURT 20874 USA items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No If Yes, Give ò Completed by 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🖔 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE "natural", Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. UNITED STATES Elementary/Seconday (0-12) College (1-4 or 5+) FEDERAL INVESTIGATOR NAVY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ EVELYN GOSSARD BOYD RUSSELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a tant: If item 27 is PATRICK CARLIN / SPOUSE 20016 WANEGARDEN CT., GERMANTOWN, MD 20874 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite injury or 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State GATE OF HEAVEN 2/5/2010 SILVER SPRING, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fusion Service Lidensee 22. Name and Address of Facility 22. Name and Address of Paulity
HILTON FUNERAL HOME
P.O. BOX 86, BARNES 20838 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) a ACUTE RENAL FAILURE, RECURRENT hrs Medical Due to (or as a consequence of) Examiner 46 days RENAL FAILURE WITH DEHYDRATION Sequentially list conditions. Examine Due to (or as a consequence of):
DRUG INDUCED RENAL FAILURE WITH SEPSIS, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events 48 days death certificate be executed CHRONIC ANEMIA PNEUMONIA burial-tran resulting in death) Last CHRONIC PULMONARY FIBROSIS WITH ANEMIA CHRONIC DUE TO MYELOID METADIAGIA Due to (or as a consequence of): physician Physician/Medical 10+ years Box 68760 the nding pl use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy jo Month Day Year Pregnant at time of death Other (specify) g | Linknown P.0. ed by t detach signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hospital or Attending Physician: The law Jas page 2: autopsy certificate 1 Yes 2 🗌 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🔁 No မ 1 🕅 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this s after death.
I Director: After this d in by the funeral d 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one ditle of certifier 29b. Signature and 29d. Date signed (Month, Day, Year) JANUARY 30, 2010

State Registrar JOHN/ J.

31. Date filed (Month, Day, Year)

18540 OFFICE PARK DR., MONTGOMERY VILLAGE,

20886

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

. Registrar's Signature

SHIGW,

			For State Registrar		State of Ma	ryland	•	artment of I r <i>tificate of</i>		nd Men		iene 19. No.2 (010	04642	
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month				Year	3. Time of Death	
	/Medic		Pauline H. Critchley					1	Februa						
	Examin	er		Name (If not institution, give street and number) relwood Nursing Home					r Location of	Death	4c. County of Death Cecil				
	Funeral		5. Social Security Number		If Under 1 Year	Elkton Under 1 Year If Under 24 Hrs. 8. Date of Birth				h 9 Birthplace (State or Foreign					
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	by	1 ☐ Never Married 3 🏹 Widowed 4 ☐		Armed Forces? 1	0		If Yes, specify Cub 1 □Yes 2 No	an; Mexican, Specify:	Puerto Rica	n, etc.)		Black, White, e cify: Whi			
72 ho		etec	15. (Specify of	Decedent's Edu nly highest grad	cation e completed)	Ţ	(Give	dent's Usual Occup kind of work done	during most of	of workina	m.	6b. Kind of	Business/Ind	dustry	
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N -	e filed v al Hygie other i vent, li		17. Father's Name (First	t. Middle. Last)			HOME	maker	18. Mother's	's Name <i>(Fir</i>					
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ary	shoul and M s mar umat	۲	19a. Informant's Name/		pe. Print)		19b. Mailir	ng Address (Street	L and Number	r or Rural Ro	ute Number,	City or Tov	vn, State, Zip	Code)	
Σ,	and 2 ealth a		Helen A. Ci	ritchley	/ daughte	r	1216	West Oce	anview	Ave.	#D No	rfo1k	, VA 2	5503	
more	inf item		20a. Method of Dispositi		Removal from State	20b. Plac	ce of Disponetery, crer	sition (Name of matory or other pla	ce) 2	2/9/20	10	20c. Locatio	on - City or To	wn, State	
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Dall	permit. Fages 1 and 2 should be flied w Department of Health and Mental Hygie Important: if item 27 is marked other it any injury or other traumatic event, it once.		21. Signature of Funera	I Service Licens	90		$ _{R}$	2. Name and Addre	and G	ee Fui	neral	Home			
		259 F. Main St. F1kton, MD 21921 23 Aart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate Interval Between										Approximate			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar TCHD, 02/01/2010, TLS Certificate of Death Amended, #20b. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DOROTHY 10:38 AM 2010 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHNH DORCHESTER CAMBRIDGE MD 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 💢 F (Month, Day, Year) 1 - 27 - 1931 Months Days Min Director 220-28-4822 78 Maryl Usual Residence of Decedent show 10a, State 10c. City. Town or Location 10d. Inside City Limits with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Md. Dorchester Rhodesdale 10e. Street and Number 10g. Citizen of What Country? Funeral 5428 Rhodesdale Vienna Road 21659 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meany injury or other traumatic event, the Mea Dochester General Elementary/Seconday (0-12) College (1-4 or 5+) Nurse's Aide 12 Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman Conaway Alma Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26132 Lillie M. Magee/Niece 3389 American Corner Rd., Federalsburg, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other placem 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02/04/2010 East New Market, Md. East New Market 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bennie Smith Funeral Home S.Main St Hurlock Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, DISORDER HDVANCED NEURO DECENERATIVE disease or condition Medical resulting in death) Examiner ACHEXIA DUEAJE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) DEMENTIA. severe and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year 1 ☐ Yes 2 ¥ 9 ☐ Unknown Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe Division of Vital Records, or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown Completed page 2 should has been Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performe certificate 1 Yes 2 No 1 ☐ Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔼 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending death. Investigation 6 Could not be Accident 24 hours after deat Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D69234 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 503 BYRN ST. JEEVAN CAMBRIDGE, MD 21613 CPM PRRABOLU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

JAN

State of Maryland / Department of Health and Mental Hygien 6 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death v 1,2010 **Physician** 4:10P M February Virginia Mae Conneway /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett 93 Shaffer Hill Road Oakland 8. Date of Birth (Month, Day, Year) 8. Date of Birth (Month, Day, Year)

July 27, 1919

9. Birthplace (State or Foreign Country)
WestVirginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 💢 F Director 234-38-8643 90 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10a State 10b. County Director 1 ☐Yes 2 No MD Garrett Oakland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 93 Shaffer Hill Road 21550 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Ma once. Elementary/Secondary (0-12) College (1-4or 5+) 11 Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Smith Carrie ပ Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 93 Shaffer Hill RD, Oakland, MD 21550 Sheila Stemple/Daughter altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition T Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bottom Cm 2-4-10 Swanton, MD 22. Name and Address of Facility Newman Funeral Homes P.A. 21. Signature of Funeral Service Licen Mally Second St., Oakland, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ear disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Des 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? e Hospital or Attending Physician: The l 24 hours after death. e Funeral Director: After this certificate ha 1 ☐ Yes 2 ☐ O 1 ☐ Yes 2 Mo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Paraesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the l within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certife Hoo64705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fourth St., Oakland, MD 21550

State Registrar

FEB - 5 2010

Dr. 31. Date filed (Month, Day, Year)

311 N. Richard Porter Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 2:25 am **Physician** ROBERT THEODORE CARTER, SR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mata La 9. Birthplace (State or Foreign MD • If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2□ F Months Days Hours Yrs 220-32-5103 75 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinating by notified at 1√Yes 2□No Director LA PLATA MD. CHARLES 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20646 7505 JOSPEH ROSIER PLACE Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: BLACK δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLYED CONCRETE CONTRACTOR Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be BERTHA V. COATES GEORGE ALBERT CARTER, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 shr Department of Health and Important: If item 27 is m any injury or other traum once. 19a. Informant's Name/Relationship (Type. Print) 7505 JOSEPH ROSIER PL. LA PLATA, MD. 20646 MARY CARTER-SPOUSE Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition SACRED "HEART" CEM. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-12-2010 LA PLATA, MD. 4 ☐ Donation 5 ☐ Other (Specify) M00479 21. Signature of Funeral Service Licenses RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 Mi Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode or dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 2 **Physician** disease or condition resulting in death) /Medical Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the death certificate be executed NEWHOLD that initiated events resulting in death) Last Que to (or as a consequence of): burial-t Box 68760, sician Physician/Medical phys the attending p for use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a o 9 Unknown 9 Unknown ئە Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>Ş</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed? Yes 2 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death
To the Funeral Director:
completely filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Post Office Con 32. Regis 31. Date filed (Month, Day, Year) State Registrar

5 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 04646 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Month **Physician** Year 9:15 AM Donald Carder Lee 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Golden Living Center Cumberland Allegany 8. Date of Birth (Month, Day, Year) Feb 10, 1928 5. Social Security Number 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Hours Min 1 □ M 2 □ F 216-22-5310 81 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Matical Experiment and Professional Profess 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Oldtown Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1730 Earl Wilson Road, SE 21555 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No Specify: ģ WW II Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) foreman CSX Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Floyd Carder Evelyn (Evans) Carder ပ 19b. Mailing Addre a Stret and Number or Rural Route Number, City or Town, State, Zip Code)
1730 Lan Wilson Road, Oldtown MD 19a. Informant's Name/Relationship (Type. Print) Patricia Carder wife MD 21555 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Hemation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 2/10/201b MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Paral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Pat/1. Enter the disease, or complications that caused the death. D, not, nter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (F disease or condition resulting in death) mediate Cause (Final Diseas **Physician** 1 rona 5-VVS /Medical Due to (or as a confequence of): Examiner Sequentially list conditions, if a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 D Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a I be detached fo 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death re Hospital or Attending P n 24 hours after death, ne Funeral Director: After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 00033280 30. Name and address of persor who completed cause of death (Item 23a) (Type, Print) KENTAVENUE CUMBERLAND, MD 625 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Elmeraa 9:40A.IM. **FEBRUARY** 2010 1aru 4a. Facility Name **of** not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 9. Birthplace (State or Country) Memoria Home 7. Age (In yrs. last birthday) Social Security Number 1915 Haryland Months Hours 1 □ M 2 🗶 F Days 95 216-14-5725 Jan Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Washington poonsbord 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Specify 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fairchild Aircraft WOOREY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dade 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daughter 102 Martinsburg, WV 25405 20c. Location - City out own, State Mary 50" 20a. Method of Disposition MORKON Drive Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12-15-2010 Great Cacapon 22. Name and Address of Pacility Hunter-Anderson Funeral 21. Signature of Funeral Service Licensee 365. Green St. Perkeley Springs, wy Approximate Interval Between Onset and Death Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line Imp diate Cause (Final disease or condition resulting in death) ADVANCED DEMISNITI EMU Due to (or as a consequence of) FAILURG MUNTUS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f shov

Funeral Director

Completed by

Be

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ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Experiment austite motified at

ould be filed within 72 hours after death with i Mental Hygiene.

t and 2 should by Health and Ment

permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once.

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

Ross

the Maryland

or Attending Physiclan: The law requires that the death certificate be executed

attending physician for use as the buria

has

After this

within 24 hours after death To the Funeral Director;

Hospital

filled in by

Medical

Examine Physician/Medical <u>ک</u> Completed Be Certification: To

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an 2 DNo 1 □Yes 26. Place of Death (Check only on

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes

25. Was case referre examiner?	d to medical
1 ☐ Yes 2 1 N	lo
27. Manner of Death	
1 Natural	5 Pendin
2 ☐ Accident	investi

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) investigation

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only

3 Suicide

4 Homicide

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

1 Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)	2 Medical Examiner: On the basis of examination and/or inve and manner stated.	stigation, in my opinion, death occurred at the time	ne, date and place, and due to the cause(s)
29h Signature and	d title of certifier	29c. License number	29d, Date signed (Month, Day, Year)

D46561

29d. Date signed (Month, Day, Year) FEB, la, 2010

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

20311 LAPPANS ROAD, BOONSBORO, MARYLAND 21713 301-432-8470

State Registrar

GHAZALA QADIR, 31. Date filed (Month, Day, Year) FEB 19 2010 \$2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Pearl A. Coffer 2010 18A Tan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Upper Marlboro 12514 Cambleton Drive Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 TXF Months Davs Hours 04-10-1935 wash., 74 Yrs Director 578-44-9555 D.C. Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Upper Marlboro MD P.G. 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 12514 Cambleton Drive 20774 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 2 🔀 No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Black 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Giant Food Store Seafood Technician 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Alma Glover <u>John H. Campbell</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12514 Cambleton Drive
Upper Marlboro, Maryland 20774 Charles B. Coffer, Jr. 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harmony Mem.Park 02-03-2010 Landover, MD Sig ature Ralph Williams, II Funeral Service, P.A. 5202 PrincetonsDelightDr., Bowie, MD20720 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Exacelbellen Physician. disease or condition resulting in death) Medical Due to (or as a consequence of): Examine SPIY67UYU Sequentially list conditions, if any, leading to in recliate cause. Enter Underlying Cause (Disease or linjury Examine Sue to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ✓ No Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should neec 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an After this certificate has autopsy performe Yes 2 🔰 Be 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Universing Home 5 Kesidence 6 Univer (Specify) Hospital: 1 ☐ Yes 2 XNo Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Suicide Investigation within 24 hours after death

To the Funeral Director: ,
completed filled in by the 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the lasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Grafifying Nurse Programmer: The test of my knowledge, death occurred at the firm date and place, and due to the cause(s) and harmonic at the firm date and place, and due to the cause(s) and harmonic at the firm date and place, and due to the cause(s) and harmonic at the firm date and place, and due to the cause(s) and harmonic at the firm date and place, and due to the cause(s) and harmonic at the firm date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 29, 2010 D42719 VOI 30. Name are address of person who completed cause of death (Item 23a) (Type, Print) Suite 118

State Registrar Dawn Carroll,

31. Date filed (Month, Day, Yea, FEB 0 1 2010

MD

ack

32. Regist ar's Signature

14300 Gallant Fox Lane

20715

Bowie,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State	State of	Marylan			nt of H te of E		and N	/lental Hyg		ZUIU	04649
			Registrar 1. Decedent's Name (First, Middle,	inou	0,0	- Catin		2, Date of Dea	Reg. No	0.	3, Time of Death			
	Physicia Medic										Jan. 2	3, D	2010 Year	1:45 P M
~ 5	Examin							, Town, or	Location of	of Death		40	c. County of Dea	th
-			Woodside Cer	nter Nursin	ng Hom	e			ilver		ing		Montgo	mery
	Funeral			6. Sex 7.		last birthday)	If Und Months		If Under	Min.	8. Date of Birt (Month, Day April 2	/ Vearl		thplace (State or Foreign
	Director		579-16-5322 Usual Residence of Decedent		87	Yrs.					April 2	5,	1922 Sout	th Carolina
	ind show at	ᇹ	10a. State 10b. County		10c. Cit	ty, Town or Loc	cation							10d, Inside City Limits
	haryla 8a-f : tiffied	Director	DC						Wash	ingt	on			1 🔀 Yes 2 ☐ No
	the h		10e. Street and Number				10f. Z	ip Code				10g. C	itizen of What Co	ountry?
	s 23a	Funeral	13 Girard S	treet NE					200	02			United	d States
	death item ner n		11. Marital Status	12. Was Deceder Armed Force	nt Ever in U. s?		Nas Dece	edent of Hi	spanic Orig n, Mexican	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit	
36	after Il", or xami	d by	1 ☐ Never Married 2 🖾 Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1	☐ Yes	2 🔼 No	Specify:				· ·	
21215-0036	atura cal E	Completed	15. Deceden	Year or Dates t's Education	5.	16a, Deced	lent's Us	ual Occupa	ation			16h I	Kind of Business	frican merican
215	an "n Medi	E E		st grade completed) College (1-4 of	~ F.\	(Give I	kind of w		luring most	t of work	ing	100.1	Mild of Business	moustry
212	withir giene er th		Elementary/Seconday (0-12)		5 +		lst	Lieu	itenar	nt			Governm	ent
pu	filed al Hy d oth	Be	17. Father's Name (First, Middle, La	ast)					18. Mothe	er's Nam	e (First, Middle,	Maiden	Surname)	
yla	ld be Ment arke	잍	Ashley Corl	Ley, Sr.]	Rosa L.	Aik	ten	
Maryland	shou and is m		19a. Informant's Name/Relationsh			1	_	,				-	or Town, State, Zi	p Code)
6)	and 2 Health		Mary L. Con	cley/ Wife	Tool 1				treet	-	Washir			20002
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 XBurial 2 ☐ Cremation		ate Zub. F	Place of Dispo cemetery cren Arl ationa	natory or	other plac	e)]	Febr	uary 1,		_ocation - City or	
퍒	iit. Pa irtme irtani injury		4 Donation 5 Other (S) 21. Signature of Funeral Service Li		N	ationa	I Ce	meter	cy .		2010			<u>Virginia</u>
Ba	permit Depar Impor any in once,		Signature of Foresai Service E	DOWN	17 AC	V 11 1					ewart fi E Washi		cal Home	, inc. 20019
			23a. Part 1. Enter the disease, or	complications that cau	sed the deat							***	JOH, 20	Approximate
	Physician/		shoc er heart failure. List of Immediate Cause (Final disease or condition			of Pro	net a	+ 0						Interval Between Onset and Death
	Medical		resulting in death)	_ d	as a consequ		JSLA					_		
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	p #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or	as a conseq	uence of):								
	scute and -trans	xar	Cause (Disease or imjury that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of:								
	ate be executed physician and the burial-transit	dical	rodaling in dodary East											
760	cate I phys s the	edi		d										
687	eath certifica attending pl	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			7 =:						23d. Date of de	alivery
Box	leath e atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnar	nt at time of	al death 3 L death 5 L	Other (.y 			28	Month	Day Year
P.O. I	ires that the des signed by the a Id be detached f	Physician/Me	g Unknown								1			
Э.	s tha igned be de	þ	Part II. Other significant conditio	ns contributing to deat	n but not res	sulting in the u	inderiying	g cause giv	en in Part i	l.				the cause of death?
rds	/ require been si should	eted									24			Probably 4 🔀 Unknown
000	faw r has b je 2 st	Completed by	<u></u>								24a. Was a		24b. Were au prior to death?	topsy findings available completion of cause of
R	sician: The la certificate ha rector, page		05 10 10 10 10								1 Tyes			s 2 🗆 No
ital	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 X No	Hospital:		1		Othe	ace of Deat er:					
<u>\$</u>	Phys r this gral di	<u>€</u>	27. Manner of Death	28a. Date of i	njury	ER/Outpatier 28b. Time of		DOA 28c. Injury	4 🕮 Nu		ome 5 L Resid		6 Other (Spec	cify)
n	nding Phy tth. : After thi e funeral	cate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investig	9	Day, Year)	injury	M	work	? Yes 2 🗌	- 1	200. 300030	o v v , u	.,	
Division of Vital Records,	Attendii er death. ector: At by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	not be 28e. Place of	Injury - At ho	ome, farm, stre	eet, facto	ry, office		$\overline{}$				ıral Route Number,
Ξ	talor rs aft al Dir ed in		energy realizable	building,	etc. (Specii)	y) 					City or Tow	n, State	B)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death. To the Funeral affer death. To the Funeral pirector, free this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical E		of examinatio	n and/or invest	tigation, i	n my opinia	n, death oc	curred a	t the time, date a	nd plac	e, and due to the	cause(s) and manner stated.
	the ithin 2 the ormple	ž	29b. Signature and title of certifier	Nursa Practionar To:	the best of m	y knowladga i		omed at the Oc. License		and ulas			ate signed (Mont	
	F ≥ F ŏ		> 50.	On Rettor	```				5586				,	
	1	1	30. Name and address of person v	who completed cause of	of death (Iten	n 23a) (Type, F	Print)	riD Z	3300			J	anuary	28, 2010
L	1		E. DeVaughn Be	lton, MD.,	F.A.	C.C. 3		Colu	mbia	Rd.	NW Wash	ing	ton, DC	20009
	Sta Registra	te ar	31. Date fled (Month, Day, Year) JAN 2 2010	Census - Regi	stror's Signa	ure arks					2007			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 12 per th g901 3-15-10 vt
State of Maryland / Department of Health and Mental Hygiene 04550 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 RAYFIELD COOPER 2:15 a M Tanvary Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Doctors Hospital Lanham If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral May 1, Day, Year 32 Months Days Hours Min 1 X M 2 D F NC Director 77 243-38-5245 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits **Funeral Director** notified a 28a-f DC Washington 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r 3683 Highwood Drive, SE 20020 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1951

1 X Yes 2 1953 - If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by ō 1 Never Married 2 X Married and 2 should be filed within 72 hours after 3 -1954 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced Specify: Black. Year or Dates. ?7 is marked other than "nature traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 3+ Chief Counselor DC Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ပ Helen Cooper unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Department of Health Important: If item 27 any injury or other to Washington, DC 20020 Mary Mercer Cooper - Wife 3683 Highwood Dr. SE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 1-30-2010 Lincoln Memorial Cem Suitland, MD Signature of Euneral Service Licenses Marshall's Funeral Home of Maryland Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on sent line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year I or Attending Physician: The was after death.
I Director: After this certificate has been signed by the af Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 Yes 2 🗆 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 **N**o Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation M 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or within 24 hours aff To the Funeral Di Medical Yertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 52500 death (Item 23a) (Type, Print) Good Luck Road ah State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 6 **Physician** Month 2010 Richard Timothy Driftmyer February 12:50 A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 15069 Drapers Mill Road Goldsboro Caroline If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Ohio Social Security Number 8. Date of Birth (Month, Day, Feb 25 7. Age (In vrs. last birthday) **Funeral** Hours Min. 1 X M 2 □ F Months Days 1930 79 Director 270-28-4387 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modical Examiner must be rediffied at once. 1 ☐ Yes 2 No Director Maryland Caroline Goldsboro 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 15069 Drapers Mill Road 21636 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc 1 XYes 2 No If Yes, Give Year or Dates: 1948-52 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 US Naval Warfare Center test engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Driftmyer Nina Starkey ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 151; Goldsboro, Maryland 21636 Lois M. Driftmyer/ wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Greensboro Cemetery |Feb 13 2010 Greensboro, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Fleegle and Helfenbein Funeral Home, PA PO Box 160; Greensboro, MD 21639 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I UR 9 mo. Immediate Cause (Final **Physician** LING CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. From the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Exami and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy o in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. the detached 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ cate has been si page 2 should t 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐Yes 2 ☐No 1 ☐ Yes Hospital or Attending Physician: r this certificated ral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Schesidence 6 Other (Specify) 1 ∐Yes 2 XNo ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 □Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAY 8 221 21601 Su 302; 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 09 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 5 per fh g901 3-3-10 vt State of Maryland 7 Department of Health and Mental Hygiene 04652 State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Marie D. Dobrosielski February 3:20 A^{M} Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital E1kton Cecil Social Security Number 0180 8. Date of Birth
(Month, Day, Year)
Dec. 4, 1922 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Hours ^{Country)} D**elawar**e Dec. **Director** Yrs. 221-10-87 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 X Yes 2 No New Castle Delaware Wilmington 10e. Street and Number 10g. Citizen of What Country? 1409 Cleland Course 19805 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Homemaker At Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Nicholas Fede Mary Conde 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 Cann Road, Newark, DE 19702 Anthony Dobrosielski/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 🕱 Other (Specify) Entombment Cathedral Cemetery | 2/12/2010 Wilmington, Delaware Signature of Funeral Service Licens 22. Name and Address of Facility R 259 E. Foard and Gee Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one car's non each line. Approximate Interval Between Immediate Cause (Final and Death JUNSIS Physician/ disease or condition resulting in death) Inbnaon Medical Due to (or as a onsequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease of impury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: Monte of the Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer work? 1 🗆 Yes 2 🗆 No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, within 24 hours a

To the Funeral I

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of Certifier 29d. Date signed (Month, Day, Year) Scrohder-S.MD Doa23322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.S. SOCHDEV MD 126 A E High St., ElkIn MD 21921. 126 A E tigh Sr

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY ESTHER 2010 SECRIST DILL 8:38 \mathbf{P}^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSPICE OF QUEEN ANNE'S CENTREVILLE QUEEN ANNE'S Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F Months Days Hours Min. Director 218-20-8255 84 /9/1925 MARYLAND Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD TALBOT EASTON 10e. Street and Number 10g. Citizen of What Country? ò 10f. Zip Code ıral", or items 23a o Examiner must be Funeral 10 VICTORIA COURT 21601 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 2 X No Yes Maryland 21215-0036 າer than "natural", ເ t, the Medical Exam If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 0 SEAMSTRESS SEWING other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o Department of Health and Menta Important: If firm 27 is marked any injury or other traumation once. မ HENRY CLAY WOOLFORD ANNA GREAVES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATHY MUELLER/DAUGHTER 217 UPPERMILL COURT, CENTREVILLE, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL 2/4/2010 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. SOUTH HARRISON STREET, EASTON, MD 21601
Approximat 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ineumoni Wea Medical Due to (or as a consequence of) **Examiner** month Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Examin ng physician and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury ioblastoma that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 d. attending IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death detached 9 Unknown s been signed by t. ? should be detach Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Embolus 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 perform 2 🗆 No Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending s after death. Accident 1 🗌 Yes 2 🗌 No Investigation completed filled in by the Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY S. DESHIELDS 401 PURDY STREET, EASTON, MD 21601

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

State Registrar Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ucKw 61 10 /Medical 4c. County of Death Allegan 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 701 Shadylane Westernport ma der 1 Year | If Under 24Hrs. | 8. Date of Birth | 9. Birthplace novanir lanos Date of Birth (Month, Day, 7. Age (In yrs. last birthday, **Funeral** Days Year) 1 □ M 2 K 85 Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits YYes 2□No Director Westernport MD Alleq. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 311 Poplar St. 21562 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🙀 No Specify: Specify: White Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Robert Guinn Angie Broadwater 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dewey F. Duckworth Jr.Son P.O. Box 25 Bloomington, MD. 21523 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-12-10 Bloomington, MD 4 ☐ Donation 5 ☐ Other (Specify) Bloomington Cem. 21. Signature of Funeral Service bicensee 22. Name and Address of Facility Fredlock Funeral Home William H. Frede 31 Jones St. Piedmont, 23a, Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) chologytitos acut **Physician** vecks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to lor as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of): the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 € nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 2 No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. within 24

that the death certificate be executed Records, Division or Vital Physician; Hospital or Attending

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

Dr. Jesus 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tan 4

- 9 2010

Broadway

DHMH 17 Rev 1/2001

29c. License number

Frostburg, MD.

D21244

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04655 State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2000 Rhoda Denise Davis Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Cumberland Western Md Regional Medical Center If Under 1 Year | If Under 24 Hrs Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛪 F 04 15 2 1967 Director 214-78-8030 Maryland Usual Residence of Deceden 28a-f shov 10a. State death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Garrett Swanton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral U.S.A. 21561 Savage River Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?, 1 ☐ Yes 2 XNo Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced White Completed Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Home Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Bessie Foley Cutter Robert Cutter, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Savage River Road Swanton, MD 21561</u> Joe Davis husband 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite any injury or ot Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02-<u>13-2010 | Swanton, MD</u> Murphy Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home, P.A. DOW Crs Frostburg, MD 21532 -MOQ547 60 W. Main St., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ METASTAIL CARGNOMA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Due to lor as a consequence of Cause (Disease or linjury the attending physician and hed for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 WNo
9 Unknown Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknown been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed own ble of Be

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 After this certificate has funeral director, page 2 s within 24 hours after death.

To the Funeral Director: At completed filled in by the fu

		1 L Yes 2 A No 3 L Probably 4 L Unkno
		24a. Was an autopsy performed? 1 \sum Ves 2 \lefta No 1 \sum Ves 2 \sum No No 1 \sum Ves 2 \sum No No 1 \sum Ves 2 \sum No
25. Was case referred to medical examiner?	26. Place of Death (Check onl	ily one)
1 ☐ Yes 2 No	Hospital: 1 P Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence 6 Other (Specify)
27. Manner of Death 1 → Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No	I. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b	e las pi (i) All (ii) fortan effect	

29a.	Certifier	1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as
	(Check	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the
	only one)	3 - Gentifying Nursa Practioner: To the best of my knowledge death potential at the time, dath and plane, and due to the causes(s) and memory

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

only on () B - Certifying Nursa Practioner: To the best of my Implified a distri-		
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
7.44 Mm	17/6/3	ECREUACUAC 301

28f. Location (Street and Number or Rural Route Number

Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

31. Date film (Month, Day, Year) 32. aistrar's Signature

State Registrar

2

Certificate:

Medical

4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death JANUARY 28, 2010 **Physician** HILDA DOSS 2:00 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner FREDERICK 5310 SOVEREIGN PLACE FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year 12/2/1920 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** 89 Months Days Hours 1 □ M XX F VIRGINIA Yrs. 228-18-6193 Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 📉 No WV JEFFERSON KEARNEYSVILLE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 2336 CHARLES TOWN ROAD 25430 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 2 🗆 🗓 🗸 🔾 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. WHITE Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSHUA HUFF MITA MALLORY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) " Pages 1 and "

"ment of Health and "

" → m 27 is 5310 SOVEREIGN PLACE, FREDERICK, MD 21703 JEANNIE FOSS/DAUGHTER permit. Pages 1 and Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of PLEASANT CYTEW OF MEMORY)
GARDENS 20a, Method of Disposition 20c. Location - City or Town, State 1X□XBurial 2 □ Cremation 3 □ Removal from State MARTINSBURG, WV 2010 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final dementia **Physician** -12 heimers hears disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 I Inknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation or Attending 1 Natural 2 Accident Injury within 24 hours area we To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of ceptilier 29c. License number 29d. Date signed (Month, Day, Year) D51018

DHMH 17 Rev 1/2001

DK

State Registrar Benson

Ave., Baltimore, MD 21227

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

3421

Pinto

Douglas

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marguerite February 19, 2010 Dugan 10:12 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. 1 □ M XX Jan. 1957 218-68-3275 53 **Director** Washiyngton, DC Usual Residence of Decedent fshov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Directo WV 28a-f Morgan Berkeley Springs XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a Funeral 77 Lee Circle 25411 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. Black, White, etc. 0 Completed by Never Married 2 Married 1 ☐ Yes 2 XXVIo If Yes, Give filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White "natural" 3 Divorced 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 it Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event". 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk RETAIL SALES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Joseph Dugan Jeanette Marian Wolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Dugan Giessing/Sister 25111 Vista Bridge Road, Laytonsville, MD 20882 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Hagerstown Crematory 1 Burial XX Cremation 3 Removal from State 2/9/2010 Hagerstown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice Helsley-Johnson Funeral Home, Inc. M90522 95 Union St., Berkeley Springs, WV 25411 23a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Physician/ adenocarcinoma of lung disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Day signed by the a XX No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No XXX Probably 4 ☐ Unknown certificate has been signector, page 2 should h 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law performed? Yes 2 N 1 🗌 Yes : After this certifications : After this certification is funeral director, p 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 2 **XX**o 1 \square Yes ျှ 1XXInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) XX Natural 5 Pending 1 🗌 Yes M 2 🗌 No Accident Investigation To the Funeral Director: 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier XX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one within To the 29b. Signatur d title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

6

30. Name and address of person v

Brian Carpenter, M.D., 9901 Medical Center Drive, Rockville, MD 20850

A. park

no completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

D0064502

February 1, 2010

10-01005 Earl Lee Dequasie Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 10 0465

	Registrar				Death			R	eg. No.		
Physician/								Date of Dea	ith	ear	3. Time of Death
ai Examine	Earl Lee DeQ		imb = a)	12	6 Oh T			Month ebruary			1544 hrs
	Anne Arundel Med		imber)	4	b. City, Town, or Annapolis	Location of D	eath		4c. Count	ty of Deat Arunde	
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 2	4Hrs. 8	B. Date of Bir		YY) 9. Bi	rthplace (State or
Director	232-11-9075 Usual Residence of Deceder	' <u>A</u> _'	47	Yrs.	Months Days	Hours	Min.		/1962	Forei Co	gn Washington ounly)
any	10a. State 10b. Cou		10c. City	, Town or Location	on		_			-	10d. Inside City Limits
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fier d	3 Widowed 4 X	1 Yes Divorced If Yes, Give Yea	2 X No	1	Yes 2 X No	specify:			Specify	, W	hite
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d be fillental I	Earl L.	DeQuasie,	Sr.					a L. Pa			
nd 2 should be filed within 7 sith and Mental Hygiene. In 27 is marked other than aumatic event, the Medica To Be Comple	19a. Informant's Name/Relati		her		Address (Street Box 14 F						
permit. Pages and Department of Health Important: If item njury or other trau	20a. Method of Disposition			Place of Disposit	ion (Name of cem			ate	20c. Location		
ages nt of] it: If	1 Burial 2 XX Crema			crematory or othe alas Cre			2/5/	/10	Edan		MD
artmen ortan	4 Donation 5 Other 21. Signature of Funeral Sen	r Specify: vice Licenstee	K						Edgew		ral Home
Dep Imp	West 10	ale	-								MD 21037
nysician	23a. Part I. Enter the disease	or complications that ca									
	failure List only one ca	use on each line	ausea trie deatri	. Do not enter the	mode of dying, s	uch as cardia	ac or res	spiratory arre	est, shock, or h	eart	Approximate Interval
Medical	failure. List only one ca Immediate Cause (Final dise	use on each line.				uch as cardia	ac or res	spiratory arre	est, shock, or h	eart	Approximate Interval Between Onset and Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Destinee Lee Dawson M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Regional Med. Ctr. Cumberland Allegany Social Security Number If Under 1 Year 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 24 Hrs (Month, Day, Months Days Hours Min Director 1966 Yrs. 232-04-7686 Jan. Keyser, Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and the file 23 a or 28a-f sho ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ant: If item 27 is marked other than "natural", or items be notified at ury or other traumatic event, the Medital Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No **Allegany** Cresaptown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14709 Wood Street 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry L. Eversole Leona F. Crabtree 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leona F. Eversole/Mother P.O. Box 224 Rawlings, MD 21557 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Important: If it any injury or o cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) The Cumberland Crematory Cumberland, MD 21. Signature of Funeral Service Lic 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Larra M 0 Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 the sate has been signed by page 2 should be detacl ours after death. eral Director. After this certificate has t filled in by the funeral director, page 2 s

Baltimore, Maryland 21215-0036

1 Natural

29a. Certifier

31. Date filed

(Check

5 Pending Accident Suicide

Investigation 6
Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

iniury

28c. Injury at work?
1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Cumberland, MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 [29b. Signature and title of certifier

29d. Date signed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

Hemamalini Karpurapu, M.D. 12500 Willowbrook Road 32. Registrar's Signature

24 hours

To the Hosp within 24 hor To the Fune completed fil

 n_{j} \checkmark

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1/25/2010 Year **Physician** Corona Elizabeth Dash 1149A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year /12/1914 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕇 F Months Days Hours 578-26-5308 96 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County f Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show after traumatic event, the Medical Expression other traumatic event, the Medical Expression of the traumatic event. 1X Yes 2 □ No Director Montgomery Wheaton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11510 Alma St 20902 USA Funeral within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Printing Technician Elementary/Secondary (0-12) College (1-4or 5+) Federal Gov't 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be fith and Mental I William H. Jackson Mignon T. Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau Dr. Carl L. Dash/ Husband 11510 Alma St. Wheaton, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 2/2/2010 Landover, MD 21. Signatur of Fundat Service Li ensee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy St. N.W. Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertension
Due to (or as a consequence of): /Medical Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed Due to (or as a consequence of) burial-Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy

☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 mon 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) ed by the a Ö 9 Unknown 9 Unknown σ. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed <u>Gastpintestinal Bleeding</u> been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2x ☐ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 ANo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 € DOA Certification: To 27. Manner of Death 1⁴ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending ie Hospital or Attendir n 24 hours after death. ie Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fil Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Henry 31. Date filed (Month, Day, Year) FEB 0 3 2010

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Rd. Silver Spring, MD 20910

29c. License number

D58862

29d. Date signed (Month, Day, Year)

01/25/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thousand 10850AM S. Marian DeBose Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Prince Georges Lanham Social Security Number Funeral 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F (Month, Day, Year) 5/12/1914 Months Days Hours Min Director 577-60-5701 95 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges District Heights 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7805 Berry Place 20747 US 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Completed by Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 🔽 No 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Bureau of Engraving College (1-4 or 5+) Supervisor -Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charlie Smith Ruth Naomi Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Smith Corbett / Niece 7805 Berry P1. District Heights, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 😾 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2/1/2010 Fort Lincoln Brentwood, MD Signature # uneral Service L 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 23a. Part 1. Enter the disea shock, or heart failure se, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, . List only one cause on each line. Immediate Cause (Final MALIGNANT Onset and Death disease or condition resulting in death) Due to (or as a consequence of) NAU Sequentially list conditions, Examine if any, leading to immediate Physician/Medical þ Completed

Physician/ Medical Examiner or Attending Physician: The law requires that the death certificate be executed and

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at

Bose, Maria

buriale attending pl ρ has Certificate: To Be within 24 hours after death.

To the Funeral Director: After completed filled in by the funer

Medical

only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) JAN 2 8 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Division of Vital Records, P.O. Box 68760

Hospital

Cause (Disease or injury that initiated events resulting in death) Last	c. VERIPHENAL ARTENIA bue to (or as a consequence of): d. GANGNENE	ac DISEASE
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1
25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (Chec	
27. Manner of Death 1	28a. Date of injury (Month, Day, Year) 28b. Time of injury injury 28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occurred
4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

HANOVER Parkway suite 10/A Green belt, MD 2070

2010

DHMH 17 Rev 7/2009

Registrar

7500

Amended Items 19a & 19b per F.D. 02/04/2010 Carroll Co., wjl State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Audrey Pamela Daue 2010 26 11:25 PM January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll 8. Date of Birth (Month, Day, Year) June 4, 1920 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** Min 1 □ M 2 😾 F Days Hours England Director 542-38-2862 89 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21158 USA 1000 Weller Circle Apt 112 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public Information Specialist Social Security Admin. other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Lucy May Robinson permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Reginald L. Cunningham 172 Bail Regressionet Assember oBrad teinen mar, MDr T2 la 2 la 2, Zip Code) Keligencaus ey tionshic Tandidaughter Pamela Collinson/Daughter 19 Ridge View Dr., Westminster, MD 21157-Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington National Cem 02/03/2010 Arlington, Virginia 21. Signature of Funeral Service License 22. Rivintes de Funeral Home and Chapel, P.A. aun 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician are the burial-t Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Year 1 Yes 2 L 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital Other: 2. No 1 🗌 Yes ဂ္ 1- Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1- Natural 5 Pending nours after death.

neral Director: Aff 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 26 2010 D0059552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TWA POOLE RD WESTMINSTER 21157 GOURISHANKAR C MAGRINA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 8 2010 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Richard Dodson 2010 Jan28, 8:25 P.M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 4710 Maui Street Prince George's Clinton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 15, 19 **Funeral** 7. Age (In vrs. last birthday) Days Hours 2□ F Director 577 54 9501 68 1941 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'm Mudical Evanthat must be notified at annotes. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD P.G. Clinton 1 ☐ Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4710 Maui Street 20735 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXVo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2√TNo Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard L. Dodson Alice M. Daras ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Dodson (Wife) 4710 Maui Street, Clinton, MD 20a. Method of Disposition

1. ABurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Resurrection Cemetery 2/4/2010 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of uneral suce icensee 22. Name and Address of FacilityLee Funeral Home, inc 6633 01d 21. Signatu Alexandria Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** pr disease or condition resulting in death) , /Medical Examiner uncen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Ves 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 \(\square\) Nursing Home 1∐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 5 Residence 6 ☐ Other (Specify) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

BB10

State Registrar Richard Farson, M.D. #10 St. Patricks Drive #203, Waldorf, MD 20603
31. Date filed (Month, Day, Year) 32. Pegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 0 2 2010 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 **Physician** Pau1 Oribhabor Esene Jan. 22, 6:08 a^M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince Georges Hospital Center Cheverly Prince Georges Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Hours 453-49-27 Days 1 X M 2 □ F Director Nigeria Oct. 15, 1955 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits event, the Medical Examiner must be notified at Md. Prince Georges Upper Marlboro Director 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with "natural", or items 23a or 7104 Perrywood Road 20772 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No 2 Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Hospital permit. Pages 1 and 2 should be filed wit. Department of Health and Mental Hygien. Important: if item 27 is marked other tha any hijury or other traumatic event, Texpond. Forensic Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Esene ည Grace Esene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stella Esene 7104 Perrywood Rd., (Wife) Upper Marlboro, Md. 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place)
Family Cemetery Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 02/19/2010 Lagos, Nigeria 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility H. Bacon Funeral Home, Inc. 14th Street, N.W. Washington, DC 20010 3447 23a. Parl . Enter the disease, or complications, or heart failure. List only one of the complete compl ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. **Physician** sulting in death) /Medical Due to (or as a consequence of): Examiner End Stage Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical to evens on attending p use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Day Year 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 ☐ Yes 2 ☐ No 1 X Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 15% Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Swapma 2010 D006934

CR 12

State ³ Registrar

Gaddipati, Swapna 3001 Hospital Drive, Cheverly Maryland 20785
31. Date filed (Month, Day, Year) September 1. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10a-c.e.f.perINF.G901.3/29/2010 WS

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year CALVIN Т. **EDWARDS** 0935AM Medical anuan 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON COUNTY HOSPITAL WASHINGTON HAGERSTOWN Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days Hours 10-05-1959 Director 252-98-2946 50 WINSTON SALEM, NO Usual Residence of Decedent 28a-f show of Health and Mental Hygiene. item 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10d. Inside City Limits Funeral Director Oc. City, Town or Location

Capitol Heights MD DC WASHINGTON 1 X Yes 2 No Prince George's 10f. Zip Code 20743 20018 1306 Larchmont Ave. 10g. Citizen of What Country? U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify: 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Y Yes 2 No If Yes, Give Completed by 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Specify: BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12TH GRADE College (1-4 or 5+) CHEF SELF EMPLOYED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be **JAMES** EDWARDS RICHARDSON ROSA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EUNICE Z. TAYLOR-EDWARDS-WIFE 2818 EVARTS ST., N. E. WASH., DC 20018 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) LEE CREMATORY 2-3-2010 CLINTON, MD 21. Signature of Funeral Service Licenses PINCKNEY-SPANGLER F. H. 22. Name and Address of Facility 524 - 8TH ST., N. E. WASH., DC 20002-5236 23a. Part 1. Enter the disease, or complications that caused the death o not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death thysician/ disease or condition resulting in death) ICATION SCONOACH OMPL さんり ら Medical Due to (or as a consequence of): Examiner 75 YPERTENSION Secuentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed and -trans that initiated events physician ar s the burial-t resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year 2 No ed by the a detached f 9 Unknown Unknown P.O. s been signed b Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, EDEMA CMODARY 1 Yes 2 No 3 Probably 4 Unknown CHRONIC 24b. Were autopsy findings available prior to completion of cause of DV30105E 24a. Was an has page 2 autopsy performed? Yes 2 No this certificate death? 1 Yes 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 \(\subseteq \) No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29b. Signatul 29c. License number D0056965 MO FACED 28 s of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

32. Registras's Signa

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FEB 0 1 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		rtificate of Death		/giene Reg. No. 2010	04666
ı	Physici		1. Decedent's Name (First, Middle, Last) MARY ELISE HOBLITZELL FULLER			2. Date of Di Month Jan	Day Year	
A. K.	/Medi Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of	of Death	4c. County of Dea	ath
	Funeral	•	Genesis HealthCare - The F 5. Social Security Number 6. Sex 7. Age (In yrs.)		Eastor If Under 1 Year If Under		rth 9. Bi	
	Director		215–22–0395 ^{1□ M 2} ▼ 84	Yrs.	Months Days Hours	24 Hrs. 8. Date of Bi (Month, D 4/13/1	925 MA	rthplace (State or Foreign Country) ARYLAND
	yland iow		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ty, Town or Lo	cation			10d. Inside City Limits
	e Man	Director	MD TALBOT	EASTON				1 X Yes 2 □ No
	with th	Dire	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	ountry?
	death	Funeral	610 DUTCHMANS LANE 11. Marital Status 12. Was Decedent Ever In U.	.S. 13. \	21601 Was Decedent of Hispanic Orif Yes, specify Cuban, Mexican	igin? (Specify Yes or N	USA 0- 14. Race - Am	
36	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show it Markel Ever incr. ust be notified at	by Fu	1 Never Married 2 Married		f Yes, specify Cuban, Mexican 1 □Yes 2 X No <i>Specify:</i>		Black, White Specify: W	
21215-0036	2 hour	ted b	3 ₩ Widowed 4 □ Divorced Year or Dates:	16a. Deced	dent's Usual Occupation		16b. Kind of Business	
1218	vithin 7 ne. han "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done during most DO NOT use retired)	t of working		·
	filed w Hygie other ti		12 4	<u> </u>	EACHER 18. Mothe	er's Name (First, Middle	EDUCAT:	LON
/lan	uld be Mental arked o	To Be	CHARLES LOWNDES HOBLITZELL			LISE BARRY	,	
Maryland	permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other v any injury or other traumatic event, II once.		19a. Informant's Name/Relationship (Type. Print) BETTY BARTLETT/EXECUTOR		g Address (Street and Number 1824 JASPER LA			Zip Code)
Baltimore,	les 1 au of Hea or othe		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State	lace of Disport emetery, cren	sition (Name of natory or other place)	Date	20c. Location - City or	Town, State
Ħ.	it. Pag intment intant; injury o		4 □ Donation 5 □ Other (Specify)		E CREMATION 2		STEVENSVII	LLE, MD
Ba	permi Depa Impo any ir once.		21. Signature of Funeral Service Licensee John R. MERCERS	F	Name and Address of Facility LLOWS, HELFEN		NAM FUNERAL	HOME, P.A.
Letino .	Physician	7	23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	n. Do not ente	OG SOUTH HARRI er the mode of dying, such as	SON STREET	EASTON, M	Interval Between Onset and Death
and the	/Medical Examiner		Due to (or as a consequ	uence of):	or Dist	40		LANDS
	p #	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	uence of):	es pisti	36	-	9000
	tificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	unnon off:				
68760,	te be e /sician e buria		d d	ience org.				
		Medical	IF FEMALE:					
O. Box	The law requires that the death cert ate has been signed by the attendingage 2 should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 2 No 9 ☐ Unknown	I death 3 🗆	Ectopic pregnancy Other (specify)		23d. Date of de Month	elivery Day Year
ν, σ,	res that t signed by be detac	by Ph	Part II. Other significant conditions contributing to death but not resu	alting in the un	derlying cause given in Part I.	23e. Did	tobacco use contribute t	o the cause of death?
ord	w require been signature					1 🗆	Yes 2 No 3 P	Probably 4 Weknown
		Completed				24a. Was auto perfo 1 □ Yes	psy prior to death?	utopsy findings available completion of cause of s 2 \(\square\$ No
Vital	Physician: r this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ to Hospital: 1 □ Inpatient 2 □ I	EB/Outpation:		of Death (Check only		
	ng P	$\vdash 4$	27. Manner of Death Phatural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?		idence 6 Other (Spe	эспу)
Division	Attending or death. ector: After by the fune	icati	Accident investigation		M 1 □Yes 2 □N	-		
2	ital or A rs after al Direc led in by	Certification:	4 ☐ Homicide determined 28e. Place of Injury - At homicide determined building, etc. (Specify	me, iarm, stre	et, ractory, office	28f. Location (City or To	Street and Number or R wn, State)	ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the time, date and restigation, in my opinion, deat	d place, and due to the th occurred at the time	cause(s) and manner a date and place, and du	is stated. e to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mon	th, Day, Year)
	TLS		20 Name and add a		K13333	6	FEBRUAR	4 1,2010
	5		30. Name and address of person who completed cause of death (Item Pry RESIDE CRNA GIO	Dutc	HMAN'S LANG	EAST	EN, MD =	21601
	Stat Registra	٧	31. Date filed (Month, Day, Year) FEB 0 1 2010 32. Registrar's Signat	lure bas	KN			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day ERNEST FRANKLIN FOREMAN 2010 3:55 ΡM Jan 31 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Easton Talbot Genesis HealthCare -The Pines Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1**X** M 2□ F Months Days Hours 217-36-2084 85 4/14/1924 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 DUTCHMANS LANE 21601 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FARMER **AGRICULTURE** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLIFFORD F. FOREMAN MABEL JOSEPH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES M. FOREMAN/SON P. O. BOX 40911, WASHINGTON, DC 20016 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) SPRING HILL CEMETERY 2/6/2010 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. MERCERON MOL 200 SOUTH HARRISON STREET, EASTON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WEEKS as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 attending physician for use as the buria the signed by Division of Vital Records, nours after death.

neral Director: After this

filled in by the funeral di 24 hours within 2 To the

Physician

/Medical

Examiner

Funeral

Director

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ral", or items 23a or 28a-f shore Examiner must be notified at

"natural", or items 23a

than

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the M any injury or other traumatic event, the M any once.

Physician

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Examiner

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Director

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Physician/Medical

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Completed

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Certification:

Medical

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Frank Foreman Baltimore, Maryland 21215-0036

							· ILlifes 2L	INO 3 PIODADIY 4 THERIOWIT
							24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No
25. Was case referre examiner?	ed to medical				26.	Place of De	eath (Check only o)	
1 □ Yes 2	lo l	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatient	3 🗆 [OOA Other: 4	rsing	Home 5 ☐ Residence 6	Other (Specify)
27. Manner of Death atural 2 Accident	5 Pending investigation		28b. Time of Injury	M	28c, Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe how injury	occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street	, facto	ry, office		28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
29a. Certifier 1	Cartifying Ph	vsician: To the best of my kno	wledge death o	ccurre	d at the time d	late and pla	co. and due to the course(a)	and manner or stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29b. Signature and title of certifier 30. Name and address

200

29d. Date signed (Month, Day, Year)

RS 3

State Registrar

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician Year Donald Fisher Lee 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Golden Living Center Cumberland Allegany Date of Birth (Month, Day, Feb 9, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD **Funeral** Months Days Hours Min 213-22-4025 Director 81 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the "Nedical Eventinal Injury or any ones. 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits MD Allegany Cumberland Director 1 □¥es 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1305 Michigan Avenue 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ No Specify. ģ Specify 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) White Oaks manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur L. Fisher Lelia H. (Twigg) Fisher ၉ 19a. Informant's Name/Relationship (Type. Print)
JoAnn Fisher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305 Michigan Avenue Cumberland MD MD 21502 wife 1305 Michigan Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 2/9/2010 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) come heeliceios **Physician** nyeloc heoric morete /Medical Due to (or as a consequence of Examiner Sequentially list conditions, it any factor to the first cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for es a nonsecuence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year 4 Pregnant at time of death
9 Unknown 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 □Yes 2√2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ANursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of D ath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at / Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide **Text** Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Hmar Shorter 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 V

State Registrar 31. Date filed (Month, Day, Year) & BB 1920

10 625 KENT AVENUE SLUTE 204 CUMPERLAND, MD ZISOZ 132. Registrar's Signature 132. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene sm AMEND #23A-B, PT. II 25 27 28A-F, PER ME, G953 7-1-14 Reg. No. 14669 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Fadley Naomi Jean Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany WMHS-RMC Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** Birthpia. Country) MD 1 □ M 2 □ F Month, Day, Apr 9, Months Hours Min Director <u>215-36-9877</u> 69 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Funeral Director MD Allegany LaVale or 28a-f 1 🗌 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 11114 Montana Avenue 21502 USA permit. Page 1 and 2 should be filed within 72 hours after death \(\) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other transmitted. 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: Completed white Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cumberland Floral <u>floral designer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Henry Border Jean (Hott) Border 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaVale 11114 Montana Avenue MD 21502 Marshall Fadley husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 2/5/2010 Restlawn Memorial Garderis MD 4 ☐ Donation 5 ☐ Other (Specify) LaVale 22. Name and Address of Eacility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Li 108 Virginia Avenue: Cumberland, MD 21502 23a. P. r. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **COMPLICATIONS OF HIP FRACTURE** Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ON APPROVED BY NEDICAL EXAMINER attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: f yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Dav Year signed by the at d be detached for Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy HEROSCLEROTIC CARDIOVASCULA performed? Yes 2 death? certificate 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifica completed filled in by the funeral director, I 25. Was case refer 26. Place of Death (Check only one) Be examiner? Other: ည 1 1 → Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury X Accident 5 Pending SUBJECT FELL 1 ☐ Yes 2 🕱 No $\mathbf{P}^{\,\mathsf{M}}$ Investigation 2-1-2010 3:38 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **HOME** 28f. Location (Street and Number or Rural Route Number, City or Town, State) 11114 MONTANA AVE LA VALE, MD. determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number death (Item 23a) (Type, Print) who completed State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

nyant rietoner		1- For State Certificate of D			2010	046/1
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)		Reg. N 2. Date of Death		3. Time of Death
Medical Exam		Bryant Fletcher		Month Day January 26, 2	y Year 2010	1711 hrs
		4a. Facility Name (if not institution, give street and number) 4b.	City, Town, or Location of Death		4c. County of Death	
			Seat Pleasant	T	Prince George	
Funeral Director			f Under 1 Year If Under 24Hrs. Months Days Hours Min.		M/DD/YYYY) 9. Birth Foreign	1
		579-92-4588 1 M 2 F 40 Yrs.		Sept.6,	1969 was	Sh.,DC
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
* .	L	DC Washing	ton			1 XYes 2 No
Maryland 28a-f show 1 at once.	Director		Of. Zip Code	10g. C	Citizen of What Count	try?
ith the Maryland 23a or 28a-f sho notified at once.		3452 Dix Street, NE	20019	Ur	nited Sta	ates
h with ms 23 be no	Funeral		ecedent of Hispanic Origin? (Spe specify Cuban, Mexican, Puerto R		14. Race - Americ White, etc.	an Indian, Black,
r deat or ite	Fun	1 Yes 2 X No		, 0.0.7		
ırs afte ural"	by	or Dates:	s 2 No specify: Jsual Occupation (Give kind of wo	ork done 16b	Specify: Blac	
72 hou "mat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	of working life. DO NOT use retire		. rand of Edomeson.	ducty
036 ithin ane. r thar	ldm	12 Master	Barber		Private	
5-0 iled w Hygic I othe		17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, Maide	en Surname)	. ,
21215-0036 wild be filed within 72 hours after Mental Hygiene, marked other than "natural", c event, the Medical Examiner	Be (Luther Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad		a Rudd	07 7 014	7. 0. 1.)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland calth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	ပ	11111	dress (Street and Number or Ru 14 Hanna Plac Shington DC		City or Town, State,	Zip Code)
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatic.		20a. Method of Disposition 20b. Place of Disposition	(Name of Cemetery	Date 200	c. Location - City or T	own, State
Baltimore, permit. Pages I al Department of He Important: If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other p	Memorial Ceme	2/10	Waldorf	ма
litin nit. P artme oortan ury or					Edwards E	
Balt permit. Depart Import injury	1	1 10	0 Silver Hill			
Physician		234 Part I. Enter the disease, or complications that caused the death. Do not enter the m				Approximate Interval Between Onset and
Medicul Examiner		Minimediate Cause (Final disease a. Multiple Injuries				Death
		or condition resulting in death) Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated				
rted d ansit		events resulting in death) Last Due to (or as a consequence of): d.				
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	Medical	UNPENDED AMENDED				
'60, zate be physic he bur		IF FEMALE: 23c. If yes, outcome of pregnancy		2	23d. Date of delivery	
687 certific	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal d 4 Pregnant at time of death 5 Others	_	cy	Month Da	ay Year
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unknown Other	(Specify)			
at the		Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death?
s, P.O.	d by			1 Yes 2	✓ No 3 Proba	ably 4 Unknown
rds v requi s been should	ete			24a. Was an autopsy		opsy findings available ompletion of cause of
He lay	Completed			performed¹ 1 ✓ Yes 2		2 No
Division of Vital Records, tal or Attending Physician: The law requir rs after death al Director: After this certificate has been siled in by the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director.	BeC	25. Was case referred to medical examiner?	26 Place of Death (Check on			
hysic al dire	일	1 Yes 2 No Inpatient 2 ER/Outpatient 3			dence 6 🗸 Other:	Scene
n of ding Ph		27. Manner of Death 1 Natural 5 Pending San Date of Injury (Month Day ear) 1 Author 2010 1646 hrs		8d. Describe how in perator in mo	njury occurred torcycle-motor v	ehicle collision
Division pital or Attent ours after death neral Director:	Certification;	2 Accident Investigation 280 Place of Injury. At home farm street for		8f Location /Street	and Number or Pur	al Route Number, City
Divi		Suicide 6 Could not be determined (Specify) Major Road / Highway		or Town, State)		et, Seat Pleasant, M
Hospi 14 hou Funer ely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred control of the control of th				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, and manner stated				
E 3 E 8	ž	29b. Signature and title of certifier	29c, License number	290	d. Date signed (Mont	h, Day, Year)
		Carol Hallan	O.C.M.E.	Ja	nuary 27, 2010	
7	Ì	30. Name and address of person who completed cause of death (Item 23a)				
		Carol Allan, MD Assistant Medical Examiner 111 Penn Stre	et, Baltimore, MD 21201			
St Regist	ate trar	31. Date filed (Month, Day, Year) FFR 0 1 2000 Live 2. Samely				
DHMH 17 Rev 1/2	_	OGME ORIGINAL				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month FORBES LEROY MARVIN P TANIJARY 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death PRINCE GEORGE'S Examiner 4b. City, Town, or Location of Death CLINTON SOUTHERN MARYLAND HOSPITAL 5. Social Security Number 6. Sex 1 ፟፟ M 2 ☐ F 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours MAY 15 34, 19943 VPROINIA **Director** 66 227-54-7081 Usual Residence of Decedent 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PRINCE GEORGE'S TEMPLE HILLS MD 1 X Yes 2 □ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20748 4508 HARVEST ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. BLACK ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE CLERK 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Aenta Important. If item 27 is marked any injury or other traumation. ည JANE WEST MILDRED CHARLIE MCKINLEY FORBES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELMAR CRYSTAL FORBES/WIFE 4508 HARVEST ROAD TEMPLE HILLS, MARYLAND 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State CHELTENHAM, MARYLAND MD VETERANS CEMETERY 2/1/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a conseque of) Exam that the death certificate be executed the burial-transit Due to (or as a consequence of resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown ed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Physician: The law requires Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: ٩ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this (4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 3 Suicide (Month, Day, Year) injury w<u>ork</u> 5 Pendina after death. 1 ☐ Yes 2 ☐ No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knewledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

Box 68760

P.O.

Division of Vital

Registrar

29b. Signature and litle of

30. Name and address of per

moleted cause of death (Item 23a) (Type, Print

32. Regis

29c. License number

,26/20/0

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 26/2010 JAMES R. FERGUSON, SR. Medical 2:13 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Wash.DC 8. Date of Birth 1**X** M 2 □ F Months Days Hours Min Director 579-54-3998 68 Usual Residence of Decedent or 28a-f show notified at . Page 1 and 2 should be filed within 72 hours after death with the Maryland irment of Health and Mental Hygiene. Itant: If items 23s or 28a-f sho lant: If item 27 is marked other than "natural", or items 23s or 28a-f sho livry or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland Prince George's District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2128 County Road # U<mark>nited States</mark> 20747 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Truck Driver</u> Star Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Jessie Ferguson Louise Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Mable L. Ferguson / Wife</u> 2128 County Rd. #101 District Heights, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 Donation 5 Dother (Specify) Harmony Memorial 2/4/2010 Landover, Maryland Signature of Funeral Service Licensee 22. Name and Address of FacilityPope Funeral Homes, P.A. 101 US 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Arrhythmia Approximate Interval Between Onset and Death Arrhythmia Immediate Cause (Final disease or condition Physician, FATAL CARDIAC ARRIYMIA Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and shed for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part !. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available has autopsy performed? Yes 2 No prior to completion of cause of death? After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 Tes 2 🔀 No Other: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iours after death. neral Director: A l filled in by the fu 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

31, Date filed (Month, Day, Year State FEB 0 3 2010 Registrar

(Check

29b. Signature and title

certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mehdi Sattarian 3001 Hospital Drive Cheverly, Maryland 20785 32. Registar's Sig

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D0065367

29d. Date signed (Month, Day, Year) 01-26-2010

10-00776 Leo Forame Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death	.ui i i j g	Reg.	. No.	J U46/			
Physici		Decedent's Name (First, Middle,Last)		Date of Death		3. Time of Death			
edical Exami	ner	Leo Forame 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of		Month Danuary 26,	2010 4c. County of Deat	1835 hrs			
		Fort Washington Hospital Fort Washington	Deam		Prince Georg				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	r 24Hrs.	B. Date of Birth	(MM/DD/YYYY) 9. Bi	rthplace (State or			
Director		578 07 3324 1XM 2F 93 Yrs. Months Days Hours	Min.	July 20), 1916 Forei	yn Washingto DC DC			
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
*	Director	Maryland Prince George Suitland				1 Yes 2 XXNo			
Maryland 28a-f show		10e. Street and Number 10f. Zip Code		10g	. Citizen of What Cou	ntry?			
th the Maryland 23a or 28a-f sho notified at once.		2411 Fort Drive 20746			United St	ates			
0036 within 72 hours after death with the Maryland yene. her than "natural", or items 23a or 28s-f sho Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	14. Race - Amer White, etc.	ican Indian, Black,					
after c	by F	3 X Widowed 4 Divorced If Yes, Give Year WWII 1 Yes 2 X No specify:			Specify:	White			
hours natur Exam		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give ki during most of working life. DO NOT u			6b. Kind of Business/	•			
36 nin 72 than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 9th Cab Driver			Privat	oration e			
5-0036 led within? Hygiene. I other than	Com		Name (Fi	rst, Middle, Mai					
21 be findal riked	Be		ouise						
shou and N 7 is n	ပ္	19a. Informant's Name/Relationship (Type, Print) Barbara Forame (Daughter) 19b. Mailing Address (Street and Numb 3019 Bellingham							
A - 2 - 1 - 1		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Di	ate 2	20c. Location - City or	Town, State			
Baltimore, semit. Pages I as Department of He Important: If ite injury or other to		4 Donation 5 Other Specify: Cedar Hill Cemetery 2			Suitland,	•			
Baltimo permit. Page Department o Important:		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Alexandria Ferry				20735			
Physician		234. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car failure. List only one cause on each line.	rdiac or res	spiratory arrest	, shock, or heart	Approximate Interval Between Onset and			
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) The to (or as a consequence of): The to (or as a consequence of):				Death			
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.							
	ner	if any, leading to immediate Due to (or as a consequence of):	_						
=	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
760, icate be executed physician and the burial - transit		d. UNPENDED AMENDED							
60, ate be hysicia	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	<u></u>			
687 certific nding p	-	past 12 months?	pregnancy		Month [Day Year			
ision of Vital Records, P.O. Box 687 Attending Physician: The law requires that the death certific or death. ector: After this certificate has been signed by the attending ply the funeral director, page 2 should be detached for use as the content of the conten	Physician	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)							
P.O. Es that the gned by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	t I.	23e. Did toba	cco use contribute to	the cause of death?			
in of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detach.	ed by			1 Yes 24a. Was an		pably 4 V Unknown			
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ital ician: certif rector,	Be (25. Was case referred to medical examiner? Hospital. 1 Inpatient 2 FR/Outpatient 3 DOA Other 4							
n of V ling Phys After thii funeral di	٤	1 ✓ Yes 2 No lose 1 Inpatient 2 ✓ ER/Outpatient 3 DOA constant 1 Inpatient 2 ✓ ER/Outpatient 3 DOA constant 27. Manner of Death 28a Date of Injury 28b. Time of Injury 28c. Injury at Work?	Nursing He		sidence 6 Other	:			
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Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be the funeral director, page 2 should	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of Town, State)							
Divis spital or At tours after d neral Direct filled in by	Cert	4 Homicide determined (Specify)		or rown, state	e)				
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.							
To wit Con	Mec	29b. Signature and title of certifier 29c. License number		2	9d. Date signed (Mo	nth, Day, Year)			
		Carol Hallan O.C.M.E.		J	January 27, 2010)			
BQ 201	AI	30. Name and address of person who completed cause of death (Item 23a)							
M DA	AL	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201						
St Regist	ate	31. Date filed (Month, Day, Year) FEB U 2 2010 32. Registrar's Signature							

DHMH 17 Rev 1/2001 OCME 2006

OCME C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 10e per FH G900 2/19/10 dk

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Norbert Joseph Gannon 9:25 20.UUst Medical 4a. Facility Name (if not institution, give street and number, Town, or Location of Death **Examiner** 4b. City 4c. County of Death toint NGUY ec 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Hours New York 0477971928 126-22-5638 81 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Perry Point 10b. County 10a. State 10d. Inside City Limits Director MD Cecil 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 21901 VA Center--Perry Point Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Tes 2 X No Specify: If Yes, Give 3 Widowed 4 N Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Army Col., Ret Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Grace Keen Norbert Joseph Gannon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

818 Sycamore Ct.. Herndon, VA 20170 19a. Informant's Name/Relationship (Type, Print) 818 Sycamore Ct., Suzann Gannon /Ex Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Arlington National Cem. Arlington, VA 03/01/2010 4 ☐ Donation 5 ☐ Other (Specify) 721 Elden St. 21. Signature of Funeral Service License 22. Name and Address of Facility Herndon, VA 20170 Adams-Green Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Procardial Physician/ disease or condition resulting in death)) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a someographic of: Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 ☐ No 9 Unknown 1 ☐ Yes 2 ☐ Unknown detached within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Jnknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔼 Natural work? 5 Pending injury 2 🗆 No Investigation 6 Could not be ☐ Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) wen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DIC DHMH 17 Rev 7/2009

Knew To Physician: GANNON, Norbest Jacoph

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Blanche Roberson Gretter January ^{Day}9. 2010 9:15pM Medical 4a. Facility Name (if not institution, give street and number) Examiner apt.# 4b. City, Town, or Location of Death 4c. County of Death 3330 North Leisure World Blvd. 306 Montgomery Silver Spring Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Y 1 M 2 K F 578-32-2717 89 Director 1920 TN Dec. Usual Residence of Decedent 10c. City, Town or Location Silver Spring 28a-f shov 10a. State **M** D 10b. 10d. Inside City Limits Examiner must be notified at Director Montgomery 1 X Yes 2 No ō 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? apt# 23a Funeral 3330 North Leisure World Blvd. 20906 United States within 72 hours after death , or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2**No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 African 1 Yes 2XNo Specify: Specify: American "natural" 3 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Systems Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luther Roberson Jennie Nash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3330 North Leisure World Blvd., 306, Silver Spr Harrison J. Gretter /husband Silver Spring, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

■ Burial 2

Cremation 3

Removal from State Gate Of Heaven Cem | Feb 9, 2010 Silver Spring, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, NW, Washington DC 20012 Thon indre 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Stroke Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Due to (or se a consequence of) Hypertension attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Parkinson's Disease Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day Year 5 Other (specify) Month Pregnant at time of death s been signed by the should be detached 1 ☐ Yes 2 € 9 ☐ Unknown q 🗀 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 has autopsy performed certificate Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\triangle \) Nursing Home 5 Residence 6 \(\triangle \) Other (Specify) 1 🗌 Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending n 24 hours after death.

e Funeral Director: Aft bleted filled in by the fur Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sharon Yang, M.D. Leisure World Blvd., Silver Spring, MD 20906 3305

Registrar

State

31. Date filed (Month, Day, Year)

FEB 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Maryland	·				and M	lental Hy	giene	Э				
		Registrar 1. Decedent's Name (First, Middle, Last)					ertificate of Death					Reg. No. 2010 04676					
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	Medic Examir			Jacques	Greene	2	4b Cib	, Town, or	Location	of Dooth	Januar		c. County of D		6:44	4 p ^M	
- A	/ Examin	E	4a. Facility Name (if not institution, give street and number) Shady Grove Adventist Hospital					ockvi		Deam		40	Montgo		• 37		
	Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. las		If Unde	er 1 Year	If Under		8. Date of Birt	th	9.	Birthpla	ace (State	or Foreign	
	Director		078-18-3773	1 図 M 2 □ F	86	Yrs.	Months	Days	Hours	Min.	May 6,	y, Year) 192	3 N	Countr ew	York		
	d sow	_	Usual Residence of Decedent 10a, State 10b, County		100 City	Town or Lo	ontion							140	1.1. 11.0		
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	or 28	Dir	Maryland Mon 10e. Street and Number	tgomery				ville p Code			1	100 0	itizen of What	Count		5 2 🗆 140	
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	eath tems er mu	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S.		Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)						14. Race - American Indian,				
36	fter d , or i	출	1 ☐ Never Married 2 ☐ Mar	ried Armed Force 1 X Yes 2 If Yes, Give				cify Cuban 2 🔀 No		, Puerto I	Rican, etc.)		Black, W	hite, et	c.		
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lan	shoul and h is ma		19a. Informant's Name/Relationsl	nip (Type, Print)		19b. Mailin	g Addres	s (Street ar	nd Numbe	r or Rurai	Route Numbe	r, City o	City or Town, State, Zip Code)				
≥,	nd 2 ealth m 27 ner tr			ughter					ourt;	N.	Potoma	c, M	ID 2087	8			
Baltimore, Maryland 21215-0036	ye 1 a If of H If ite or oth		20a. Method of Disposition 1 D Burial 2 X Cremation	3 Removal from S		ace of Dispo metery, cren	sition (Na natory or c	me of other place)	D	ate	20c. L	ocation - City	or Tow	n, State		
tim	t. Pag tmen rtant: njury		4 Donation 5 Other (S	• • • • • • • • • • • • • • • • • • • •	Ft.	Linco	ln Cı	remat	ory	2/2/	2010	Bre	ntwood	, M	D		
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	icensee	211011			nd Address		01	mple T						
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Ö	Jing F h. After funera	ate	27. Manner of Death 1 Natural 5 □ Pendin	9 .	Day, Year)	8b. Time of injury	work?				8d. Describe h	be how injury occurred					
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	the Hi nin 24 he Fu rplete.	Mec	(Check 2 L Medical E	xaminer: On the basis Nurse Pactioner: To	of examination a	and/or investi	gation, in	my opinion	, death occ	curred at t	he time, date ar	nd place	and due to the	e cause	e(s) and ma ed.	anner stated.	
			29b. Signature and title of certifier	20	_(^^		290	. License r	number			29d. Da	te signed (Mo	n <i>th, D</i> a	y, Year)		
	10+1		1 2	D62435						1/28/2010							
			30. Name and address of person v										_				
	Charles		Sayed Elsayyac 31. Date filed (Month, Day, Year)		0110 Mo	ro.		ive;	Rock	vill	e, MD 2	2085	0				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ESTHER M. GRANDE Medical January <u> 2010</u> 4:40 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BERLIN NURSING HOME BERLIN WORCESTER 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 X 5-16-1922 189-22-1478 PENNSYLVANIA **Director** 87 Usual Residence of Decedent or 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND WORCESTER BERLIN 1X Yes 2 ☐ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 9715 HEALTHWAY DRIVE 21811 US 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No sther Grande Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE Completed 3 X Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER NONE Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LESTER PARKER ETHEL SCHLECTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FLORENCE J. SHOGI/DAUGHTER 149 PETHERTON DRIVE, BETHANY BEACH, DE. 19930 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State MELSONS CREMATORY 4 Donation 5 Other (Specify) 2-2-2010 FRANKFORD, DELAWARE 21. Signature of Funera 22. Name and Address of Facility
MELSON FUNERAL SERVICES, LT
38040 MUDDY NECK RD, OCEAN complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disea shock, or heart failure / iv only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a con) equence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Completed by Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ the atter in the past 12 months?
1 Yes 2 No been signed by t should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of ate has t page 2 s autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 XNo I or Attending Physician: I after death.
Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \sum Yes Other: 4 M Nursing Home 5 - Residence 6 - Other (Specify) ျှ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 Yes 2 No filled in by the 1 Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сопріете (Check Certifying Nurse Practioner: To the best of my knowledge at the time, date and place, and due to the cause(s) and mainer as stated 29b. Signature and title of certilier

State Registrar

DHMH 17 Rev 7/2009

9715 Healthway Dr,

Berlin,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

32. Registrar's Signature

Pennie Savage,

FEB 0

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

February 1, 2

MD 21811

2010

10-00902 Stephen Gleaton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Stephen Gleator		State Of Marylan 1-For State Registrar		ificate of		wentai n		eg. No. 20	10 04678
Physicia Medical Exami		1. Decedent's Name (First, Middle, Last)	C1				2. Date of Dea Month February	th Day Year	3. Time of Death 0028 hrs
)		Stephen Christophe 4a. Facility Name (if not institution, give street and number of the street a	r Glear		b. City, Town, or Lo	cation of Death	February	4c. County of [
-1		Easton Memorial Hospital			Easton			Talbot	
Funeral Director		216-19-8208 1XM 2_F	Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min.	7	22,1974	9. Birthplace (State or or oreign CountryIndiana
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location	on			<u> </u>	10d. Inside City Limits
	5	Maryland Caroline	Rid	lge1y					1 X Yes 2 No
Maryl	Director	10e. Street and Number	•		10f. Zip Code			0g. Citizen of What	
7th the 3.23a o	a D	212 Central Avenue 11. Marital Status 12. Was Deced	ent Ever in U.S.	13 Was	21660 Decedent of Hispa	unic Origin2 / Sn			ates of Americ
death w	Funeral	1 Never Married 2 Married Armed Forc			s, specify Cuban, N			White, e	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatite event, the Medical Examiner must be notified at once.		17. Father's Name (First, Middle, Last) Bobby Lee Gleato	n		18.	Mother's Name Linda		Maiden Surname)	
212 212 buld be Menta marke	To Be	19a. Informant's Name/Relationship (Type, Print)	11	19b. Mailing	Address (Street a			mith nber, City or Town, S	State, Zip Code)
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Division of Vital Records, ra dectords, ra after death. al Director: After this certificate has been is led in by the funeral director, page 2 should be	Completed						autops perfor 1 ✓ Yes	med? deat	
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Divis spital or At cours after d neral Direct filled in by	Certification:	4 Homicide determined (Specify)	esidenc	ce		ļi.	Ridgely	tate212 Cen	Ave
9 7 7 7		29a. Certifier 1 Certifying Physician: To the best of one) 2 Medical Examiner: On the basis of e							
To with To I	Medical	29b—Signature and title of certifier		Đ	29c. License n			29d Date signed	
		July latter lels	6	, ,	O.C.M.I	E.		February 1, 2	010
	ľ	30. Name and address of person who completed cause of Victor Weedn MD JD Assistant Medic			enn Street, Balt	timoro MD	21201		
Sta	ite	31. Date filed (Month, Day, Year) 32. Regis	trar's Signature			uniore, MD			
Registi		FER 19 2010 Anna	1 1. 1	barks	9				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De Physician/ Month Year 1:15 PM LEE GRIFFIN JAMES. January 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Montgomery General Olney Montgomery 8. Date of Birth (Month Day, 14, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Days Min. 1 ☒ M 2 ☐ F Months Hours 579-64-3247 Washington. 'T948 Director 61 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Prince George's Silver Spring 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 USA 1206 Be1 Pre Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. African 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Completed by 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: American 3 Widowed 4 Divorced Year or Dates permit, Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natuany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Griffin Pickett Earnestine Oglesby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tijuana G. Griffin, Sister 4805 Greencastle Road, Laurel, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Harmony Memorial Park 02/04/2010 Hyattsville, MD 4 Donation 5 Other (Specify) 21. Signature 22. Name and Address of Facility Jordan Funeral Service, Inc. 4001 Benning Rd., NE, Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ A nummonia Multi-lobar disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** 7 Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death detached the g Unknown g 🔀 Unknown à Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be dev Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe certificate Yes 2 No 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 은 1 🗌 Yes 2 No ER/Outpatient 3 DOA 1 Inpatient 2 -4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 54996 2010 January Name and address of phrsop who completed cause of death (Item 23a) (Type, Print) 20832 Bichhuon 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04680 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Frederic N. Gamble 28,2010 11:25A January 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cheverly
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Prince Georges Hospital Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 25, 1934 Birthplace (State or Foreign Country) 1⊠M 2□ F Months 75 NĆ 246-42-5770 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No PG Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2920 Sunset Lane 20746 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1952 1955 Specify: Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Operator Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mishuer Murphy Sylvia Gamble 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2920 Sunset L Sull and, Ad. Lane 1. 20746 2/9/10^{to} Shirley Brooks/daughter 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Md. Veterans Cemetery Cheltenham, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septic Shock Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Polymicrobial Septicemia Pneumonia Due to (or as a consequence of): Urinary Tract Infection 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? (es 2/2/No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: 1 patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Lesmit. Pages 1 and 2 should be files.
Department of Health and Mental Important: If teem 27 is many Injury or other **Physician** /Medical Examiner physicien and s the burial-transit attending pl

Physician

/Medical

Examiner

10a. State

MD

8

Funeral

Director

Items 23a or 28a-f ehow

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"natural"

other than

death \

filed within 72 hours after

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

Directo

Funeral

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Completed

Be

Examine Physician/Medical ፩ Be Completed Medical Certification:

IF FEMALE:

2 Accident

3 Suicide

29a, Certifier (Check only one)

4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. signed by the a certificate has been s rector, page 2 should : After this certification at the state of t within 24 hours after death.

To the Funerel Director: A completely filled in by the fu

State Registrar 29b. Signature and title of certifier

5 Pending

investigation

6 ☐ Could not be determined

and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Cumberbatch 3001

FEB 0 1 2010

29c. License number

Dr.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

M

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

28f. Lecation (Street and Number or Rural Route Number, City or Town, State)

Cheverly

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Stanlev Τ. January Gadomski 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft. Washington Hospital Ft. Prince George's Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 07/29/1925 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min **x** M 2 □ F 84 Director 173-20-6661 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show ral", or items 23a or 28a-f show Director 1 ☐ Yes 2/17 No Maryland 1 Prince George's Forest Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 Cree Drive 20745 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1943 Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2XXNo Specify Completed by Specify: 3 Widowed 4 Divorced White 1946 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Naval Research Lab. years Chemical Engineer is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adam Gadomski Eleanor Traczewska ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rachel Rousseau / Daughter 2682 McMullen Booth Road <u># 529 Clearwater, Florida 33761</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State 2/5/2010 4 Donation 5 ☐ Other (Specify) Clinton, Maryland Resurrection Cemetery 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signatur Funeral Service Licensee alas 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Paral. Enter the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronar **Physician** /Medical Examiner Sequentially list conditions Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last he law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 □ Yes 2 □ No. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has p ge 2 autopsy performed? 1 □ Ýes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Medical Certification: To this funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 1 Matural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

31. Date filed (Month, Day, Registrar

Tuan-Anh Vu

FEB 0 1 2010

11711 Livingston Road Ft. Washington, Maryland MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20<u>10</u> Physician/ Eugene J. Gray Month Jan.26 6:29A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death P.G. Southern Maryland Hospital Clinton 5. Social Security Number 8. Date of Birth (Month, Day, Year) June8, 1936 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1**y** M 2 □ 578-42-7831 Maryland **Director** 73 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo Md. P.G. Capitol Heights 1

Yes 2 □ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 20743 505 Suffolk Ave. Apt 201 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Maintenance Private Companies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Irene Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1221-105 Canyon Rock CourtRaleighNC 207610 Y. Curtis- Daughter Kim 20b. Place of Disposition (Name of cemetery, crematory or other place)
ChesapeakeCremat&r 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb.8,10 Beltsville, Md 21. Signature of Funeral Service Licenses Name and Address of Facility 22. Name and Address of Facility Robinson Funeral Home' 1313.6th St.N.W. 23a. Part 1 There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on part line. Approximate val Between et and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Year 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N this certificate 2 🗌 No 1 🗌 Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 12 No Other: ၉ 1 🗌 Yes 1 12 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Many er of Death 28c. Injury at work?
1
Yes Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral Medical 29a. Certifier 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title o certifier 29c. License number 29d. Date signed (Month, Day, Year) -24535

State Registrar

31. Date filed (Month, Day, Year)

JAN 2 8 2010

DHMH 17 Rev 7/2009

HVe.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

death with the Maryland ortant: If tiem 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at filed within 72 hours after Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be be Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic ever Pages 1

Physician

/Medical

Examiner

10a. State

Funeral

Director

Physician /Medical Examiner

for use as the burial-transit and Division or Vital Records. P.O. Box 68760. signed by the attending physician the detached for use as the buria Hospital or Attending Physician: '24 hours after death. Funeral Director: After this certifica

Director 12436 Deer Lodge Dr. Funeral 11. Marital Status 1 Never Married 2 Married þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Delivery Driver Electronics Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Fred Gower Gladys Virginia Stouffer Gower 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley L. Gower-wife 12436 Deer Lodge Dr. Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Lawn Mem. Park | 2-3-2010 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 23a. Part1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1331 Eastern Blvd. North Hagerstown, MD 21742 Immediate Cause (Final ancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ostructive 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 😿 No 1 Inpatient 2 ER/Outpatient 3□ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hayerstown MO 21742 14014 Marsh

State Registrar

Year)

FEB 0.2

31. Date filed (Month, Day,

within 24 hours at To the Funeral D

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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			for State Registrar	State of	IVIA	i yiai i		tificate			IIU IVIC	-	Reg. No.	0.0	1.0	0.1	# 0.1
			Decedent's Name (First, Middle)	e, Last)							2	2. Date of De	ath	~ U	1-U	3. Time	of Death 4
	Physici /Medio		Maryann Mo	nica H	utc	hing	S				١,	Month Januar	Day v 26	, 201	e ar O	6:51	a M
	Examin		4a. Facility Name (If not institution					4b. City, To	own, or Lo	ocation of				County of		0.51	
			Shady Grove A						_	ckvi						omery	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☑ F	7. Age		ast birthday) Yrs.	If Under 1 Months [f Under 24 Hours	Min.	3. Date of Birt (Month, Da	y, Year)				or Foreign
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rylan	how	_	10a. State 10b. County			10c. City	y, Town or Lo	cation							10	d. Inside (-
a Ma	8a-fs	Director		gomery		Roc	kville										s 2 No
with #	a or 2		10e. Street and Number	11.0				10f. Zip Ci					-	izen of Wh			
path	ns 23	Funeral	2 Manakee Road	12. Was Dece	dent F	ver in U.S	S. 13.V		0850	anic Origi	in? (Snec	ifv Yes or No		Unite			
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Z15-0036 this 72 hours after death with the Maryland	ited Hygiene. stocket than "natural", or items 23a or 28a-f show event, it with clost Evan in the visit by items at	d by	3 ☐ Widowed 4 🔯 Divorced	If Yes, Giv Year or Da				I∐Yes 2∑	XINO S	Specify:				Specify:	Whit	e	
- 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2	"natu	Completed	15. Decedent (Specify only highes	's Education of grade completed)			16a. Deced	lent's Usual (kind of work o DO NOT use	Occupation done duri	on <i>ing m</i> ost o	of working	,	16b. Ki	ind of Busi	ness/Ind	ustry	
- 5	than	m d	Elementary/Secondary (0-12)	College (1	4or 5+	-)		logist					Hea1	lth &	Hum	an Se	rvices
D B	al Hygie other I	Be C	17. Father's Name (First, Middle,					TOGISE		B. Mother's	's Name (First, Middle,			Han	all be	TVICCE
yland wid he file	and Mental last marked of umatic eve	To E	James	Johnston	n					Lil:	lian		Di	etz			
Mary	is mg		19a. Informant's Name/Relationsh				19b. Mailin	g Address (S	Street and	d Number	or Rural	Route Numbe	ər, City o	or Town, St	ate, Zip	Code)	
6, 6	Health		Lillian Johnsto	n / Mothe:	r	Look D				ive;	Vass	, NC 2			* To	un Ctata	
OL Segre	nt of I		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation		State	1	lace of Dispo emetery, cren							ocation - Ci			
Baltimor	artme ortani Injury		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service I			Met	ropoli	. Name and						xandı	ia,	VA	
מ פ	Department of Health and Mental Health and Mental Health and Industries any Injury or other traumatic even once.		MSA		M01	463	/			-		nple Ti , Rock			208	352	
			23a. Part 1. Enjer the disease, or shock, or heart failure. List	complications that ca	aused t	he death								0, 111		Approxima Interval Be	ate
P	hysician		Immediate Cause (Fin				nfarct	ion								Onset and	Death
	Medical		resulting in death)				ience of):	2011								minu	
E.	xaminer	<u>.</u>	Sequentially list conditions,	b													
ted	nsit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	Due to (or as a	consequ	ience of):										
ou, be executed	n and ial-tra	Exar	that initiated events resulting in death) Last	c Due to (or as a	consequ	ience of):										
• e	9 8	call		d													
rtifica	ng ph as th	Medi	IF FEMALE:		-								-				
ath cer	ttendi or use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo	irth 2	₽ 🗀 Fetal	death 3	Ectopic preg	gnancy				- 1	23d. Date		ry Day	Year
- ક ક	the a	ysic	1 ☐ Yes 2 X No 9 ☐ Unknown	4 🗌 Pregn 9 🔲 Unkno		time of d	eath 5□	Other (spec	cify)					1410114		Duy	7001
that	ned by detac		Part II. Other significant condition	ns contributing to de	ath but	not resu	Ilting in the ur	derlying caus	se given i	in Part I.		23e. Did to	obacco ι	use contrib	ute to th	e cause of	death?
COLOS « requires	an sign	d by	COPD, Lung Can	cer, Recer	nt (GI B	leed					101	/es 2	□ No 3	☐ Prob	ably 4⊠	Unknown
aw re	2 sho	Completed										24a. Was		24b. We	re autor	sy findings	s available
T Per	ate ha	mo		1.0		·						autop perfo 1 ☐ Yes	rmed?	dea	or to con ath?]Yes	npletion of 2 □No	cause or
VILCAL ician:]	ertific actor,	Be (25. Was case referred to medical examiner?							6. Place o	of Death (Check only o					
P Pysi	this o	ျှ	1 ☐ Yes 2 ☐XNo 27. Manner of Death		<u> </u>		ER/Outpatien					e 5 ☐ Resid			(Specify)	
ding	h. After funer	tion	1 Natural 5 ☐ Pending		h, Day,	Year)	28b. Time of Injury	M 280	: Injury at Work? 1 □√os	τ s 2.∐No		ld. Describe l	now injur	y occurred			
Atten	after death. Director: A in by the fu	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place	of Injur	y - At ho	me, farm, stre			3 2		f. Location (5	Street an	d Number	o <i>r Rur</i> a	Route Nu	mber,
2 5	# 5.5	Certification:	4 Homicide determi	buildir	ıg, etc.	(Specify	′)					City or Tov	vn, State)			
To be solved to the hospital or Attending Physician: The law requires that the death certifical	within 24 hours a To the Funeral C completely filled			g Physician: To the Examiner: On the ba													(s)
the	thin 2	Medical	one) 29b. Signature and title of certifier	and mann					License nu		-			te signed (
Ľ.	≥ 2 8	_	Anut 1/.	4.0						amber						Jay, rear)	
•			30. Name and address of person v	who completed cause	of de	ath (Item	23a) (Type		4068				2/.	2/201	U	-	
			Amit Kalaria				al Cent		ive,	Rock	kvill	e, MD	208	50			
	Sta	_	31. Date filed (Month, Day, Year)	0040		's Signat	. Ja	11									
	Registr	ar	red (a	LUIU CRI	usa.	1 /	· Lapa	and the same of th									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	artment of Health and N		ene g. No. 2010 01.695
	Physici		1. Decedent's Name (First, Middle, Last) David North Hamer		2. Date of Death Month February	Day Year
-	/Medi Examir		4a. Facllity Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1 Con costy	4c. County of Death
-50			616 Mississippi Avenue	Silver Spring		Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	9. Birthplace (State or Foreign Country)
-	Director	ļ	219–42–4996 123 M 2 L F 65 Yrs.		Aug. 6, 1	944 New Jersey
	ow ow		10a. State 10b. County 10c. City, Town or Le	ocation		10d. Inside City Limits
	Many a-f sh	ţċ	Maryland Montgomery Silv	ver Spring		1 ∑ %/es 2 ∐ No
	or 28	ire	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	23a	ral	616 Mississippi Avenue	20910		USA
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modeal Everninar must be notified at	by Funeral Director	1 □ Never Married 2 TX Married 1 □ Yes 2x □ No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 □ Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
9	2 hou	ted	15. Decedent's Education 16a, Dece	dent's Usual Occupation	1	6b. Kind of Business/Industry
2	thin 7 e. an "n	Jple	(Specify only highest grade completed) (Give life.	kind of work done during most of worki DO NOT use retired)	ing	
7	filed wii Hygien ther th	Completed	12 Office	Technician		Verizon
/land	should be fill and Mental H s marked oth umatic even	To Be	17. Father's Name (First, Middle, Last) John Allen Hamer	18. Mother's Name Decle	e (First, Middle, Mi Louise Rei	
, Mar	and 2 sho ealth and n 27 is ma		1 2 2 4 4 1	ng Address <i>(Street and Number or Rura</i> Mississippi Avenue, Si		
e e	Pages 1 annung Pages		20a. Method of Disposition 1 DXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Shington Cemetery Fe	b. 5	Oc. Location - City or Town, State delphi, Maryland
Balt	permit. Pag Department Important: I any Injury o once.			2. Name and Address of Facility Francis J. Collins Fun 500 University Blvd. W	eral Home	Inc.
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			
F	hysician		Immediate Cause (Final disease or condition Chronic Obstructive P	ulmonary Disease		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
	=xammer	_	Sequentially list conditions, if any, leading to immediate. Due to (or as a consequence of):			-
	ted 1sit	Examiner	if any leading to immediate cause. Enter Underlying Quese (Disease or injury			
	execu n and al-trar	xar	that initiated events c. resulting in death) Last Due to (or as a consequence of):	-		
3760	cate be executed physician and the burial-transit	dical E				
89	certificate be executed ading physician and ise as the burial-transit	edic	u.			
Ď	atter after for u	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
rds, P	To the hospital of Attending Prysician: The law requires that the of the control of the control of the control of the control of the completely filled in by the funeral director, page 2 should be detached to oppose the completely filled in by the funeral director, page 2 should be detached to oppose the control of the c	ρ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		acco use contribute to the cause of death?
Hecord	he law rec has bee ge 2 shou	Completed			24a. Was an autopsy performs	24b. Were autopsy findings available prior to completion of cause of death?
VITAL	ifficate		25. Was case referred to medical		1 □Yes 2	No 1 ☐ Yes 2 ☐ No
>	ysicia s cert directo	o Be	examiner? 1 ☐ Yes 2 🖾 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	26. Place of Death		
0	g rny erthis	L.	27. Manner of Death 28a. Date of Injury 28b. Time of	IL 3 DOA 4 D Nursing Hor	me 5{-] Residen 28d. Describe how	ice 6 Other (Specify)
VISION	ath. rr: Aff	atio	1 Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No		
DIVIS	al or Atte s after de al Directo ed in by th	Certification: To	3 ☐ Sulcide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, str building, etc. (Specify)	set, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
1000	n 24 hour n 24 hour ne Funera pletely filla	edical (29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the car red at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)
1	To the comp		29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Day, Year)
	14	-	1000	1005176	0	7/1/2010
			30. Name and address of person who completed cause of death (Item 23a) (Type, Matthew McAndrew, MD 1355 Piccard Drive, I			•
	Stat Registra	_	31. Date filed (Month, Day, Year) FEB 0 4 2010 32. Registrar's Signature	es.		

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ JANUARY 2010 2:45 DAVID WILDER HANKINS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SUBURBAN HOSPITAL MONTGOMERY BETHESDA Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** DC Country) 1 ፟ M 2 ☐ F Months Davs Hours Min. MAY 16^{ay,} 1949 Director 60 579-64-1857 + Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 X Yes 2 No SILVER SPRING MD MONTGOMERY 3/10 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9612 EVERGREEN STREET 20901 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. AFRICAN O I S 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 5-0036 1 X Yes 2 ☐ No Specify: 3 Widowed 4 A Divorced AMERICAN Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry
MONTGOMERY COUNTY (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) RIDE ON BUS OPERATOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1740 ည NEHEMIAH H. HANKINS OSTEIN WILDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 311 UNIVERSITY BLVD. EAST, SILVER SPRING, MD 20901 EPPIE O. HANKINS/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date NENS 1 X Burial 2 Cremation 3 A Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/29/2010 LINCOLN BRENTWOOD, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility MCGUIRE FUNERAL SERVICE, INC. 7400 GEORGIA WASHINGTON.DC AVENUE, N.W. X 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of): Examine LEG CELLULITIS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month 4 Pregnant a Pregnant at time of death is certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 To the Hospital or Attending Physician: The within 24 hours a ler death.

To the Funeral Director: After this certificate h 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🔀 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 X Natural 5 Pending 2 🗋 No Accident Suicide Investigation ompleted filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier 29c. License number D-27660 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALPANA GOSWAMI, 11125 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 M.D.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen G. Hape January 2010 5:51p Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Citizens Nursing Home Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) u1v 20,1907 1 □ M 2 🕱 F Months Days Hours Min. Director 214-28-5527 102 Tu<u>ly</u> Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No <u>Maryland</u> Frederick Frederick ō 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 21702 United States 1900 Rosemont Avenue permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify 3 X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Jessica Stull Charles Firor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madison Street, Frederick, Maryland 21701 Doris Caudill/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/3/2010 Thurmont, Maryland Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Stauffer Funeral
1621 Opossumtown Homes Pike, Frederick, Maryland21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conseque **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 🔲 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year signed by the a d be detached for 1 Yes 2 Junknown Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed Yes 2 2 🗆 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Other: ဂ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation s after deat Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in Hospital within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred to the cause and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred to the cause and place, and due to the cause(s) and manner stated. completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar 30. Name and address of per-

Day, Year)

31. Date filed (Month.

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 04688 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 2:10 P M Johnnie Hurley January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington 2815 Chestnut Grove Road <u>Keedysville</u> 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 2. 1942 1 🛛 M 2 🗆 F Months Davs Hours Min. Director 400-58-9583 67 Dec. Kentucky Usual Residence of Decedent 28a-f show 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 K Yes 2 No Maryland Frederick Frederick 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a 700 Motter Avenue 21701 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc ò Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White If Yes Give Year or Dates. Vietnam Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Painter Home Improvement other Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy.
Important: If Item 27 is marked out
any Injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Berlin Hurley Bertha McCoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecil Hurley / Brother 15301 Comus Road Boyds, Maryland 20841 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State Februar 4 ☐ Donation 5 ☐ Other (Specify) 2, 2010 Resthaven Mem Gardens Frederick, Maryland Signature of Fune Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final Onset and Death NON-PMALL CELL LING CANCE Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) anding physician and use as the burial-transi death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 4 □ Pregnant 9 □ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has by page 2 s autopsy performed? Yes 2 N this certificate 1 Yes 2 🛛 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending 1 Yes Accident Suicide Investigation 6 Could not be

P.O. Box 68760 Records, Division of Vital Hospital or Attending Physician: To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af filled in by the

2+1 VA State Registrar

DHMH 17 Rev 7/2009

Medical

4 Homicide

29a. Certifier

(Check

Date filed (Month, Day, Year)

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

SOLW. SENENTY ST. FREPERICK MD

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amended #17,18 perFH, FCHD, LECertificate of Death 2/5/10 2. Date of Death Physician/ FEB LILLIAN MAYBELLE FJERESTAD HANSEN 2010 2:45A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner BETHESDA** MONTGOMERY BETHESDA HEALTH & REHABILITATI Social Security Number 7. Age (In yrs. last birthday) If Under 1_Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** 1<u>920</u> Days (Month, Day, PR 17 1 M 2 X F Months Hours Min. Country) 89 **Director** 503-01-8700 SD Usual Residence of Decedent 28a-f shov 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MINNEHAHA SIOUX FALLS SD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 57104 USA 706 SOUTH LAKE AVE. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: If Yes, Give Year or Dates. WHITE Specify: Completed 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working NEW NEIGHBOR 1 and 2 should be filed within 72 of Health and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) WELCOME SERVICE BUSINESS_OWNER other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PEDER မ ANNA KARINA STENSLAND ANDREW PETER FJERESTAD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20837 MD DR. CAROL RAE HANSEN/DAUGHTER 14921 SUGARLAND RD., POOLESVILLE, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Page 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State STAUFFER CREMATORY 2/2/2010 FREDERICK, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE 20838 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ PNEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year been signed by the should be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2-No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ၉ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ENBro, UND 00057124 2/11/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 MEDICAL CENTER DR. #201, ROCKVILLE, MD 20850 TRUONG BAO, MD31. Date filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 17 Rev 7/2009

Registrar

FEB 02

Harnson, Patricia

				Plea	se Type or												
		-	For State Registrar		State	of Marylar		tificate			and iv	ientai ny	Reg. No.	201	0 04690		
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	Funeral Director		5. Social Security Number 347–12–78		6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. 87	last birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs Min.	8. Date of Bir (Month, Da 10/21/	rth 97, Year) 1922	9. Bi	irthplace (State or Foreign ountry) MONTANA		
	nd now	١	Usual Residence of Dec	edent			ity, Town or Lo	cation							10d. Inside City Limits		
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Baltimore,	. Page 1 ar tment of Ha tant: If iter jury or oth		20a. Method of Disposit 1 X Burial 2 C 4 C Donation 5	remation	3 ☐ Removal from pecify)	State	Place of Dispo cemetery, cren RING HI	natory`or oth	er place		2/3/	2010			or Town, State		
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Record	ding Physician: The law require h. After this certificate has been si funeral director, page 2 should	omplet						<u>-</u>				24a. Was auto perf		prior to death?	utopsy findings available completion of cause of		
tal	cian: 7	Be	25. Was case referred to examiner?		Hospital:				26. Pla		ath (Check		2 32 110				
of Vi	y Physical P	e: 1	1 Yes 2 XNo		1 X 28a. Date	Inpatient 2 C	28b. Time of		<u> </u>	_4 ⊔ N		me 5 Resi			ecify)		
Division of Vital Records,	Attending er death. rector: Afte by the fun	Certificate:	27. Mather of Death 25c. Injury 25c. Inj							ctory, office 28f. Location (Street and Number					ural Route Number,		
Δİ	Signature and rite of certifier 1 Secretifier 28e. Place of Injury - At hor building, etc. (Specify) 29e. Certifier 28e. Place of Injury - At hor building, etc. (Specify) 29e. Certifier 29e. Certifier 29e. Signature and rite of certifier 29e. Signature and rite of certifier 29e. Signature and rite of certifier 29e. Place of Injury - At hor building, etc. (Specify) 29e. Place of Inju						c. (Specify) City or Town, State) f my knowledge, death occured at the time, date and place, and due to the cause(s) and examination and/or investigation, in my opinion, death occurred at the time, date and place,						ause(s) and and place, a	nd due to the	e cause(s) and manner stated		
	To the within 2 To the Formplet	ž		Certifying	Nurse Practioner:			death occurre	d at the				he cause(s) a	ind manner a			
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	RS8		30. Name and address of Benneth	of person v	who completed caus	se of death (Iter	, , , , .		20.1	70	C+	, Eas	ton	oo -l	24.01		
	Star Bogistr	e	31. Date filed (Month D	B)	2 2010 32.5	egistrar's Signa		La el	-	UII	<u> </u>	, cas	SIUTI,	ma	41001		

		1 - State Registrar	State of Maryland	/ Department of Health and N Certificate of Death		2010 0469
Physic		Decedent's Name (First, Middle	, _{Last)} Barbara Hobbs		2. Date of Death Month February	Day Year 3. Time of Death 8 2010 1130 A
/Medi Exami		4a. Facility Name (If not institution		4b. City, Town, or Location of Death	T CDI dai y	4c. County of Death
		Caraway Manor 5. Social Security Number	6. Sex 7. Age (In yrs. last	E1kton birthday) If Under 1 Year If Under 24 Hrs.	9 Date of Birth	Cecil 9. Birthplace (State or Fores
Funeral Director		221-18-9826 Usual Residence of Decedent	1 □ M 2 X F 78	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y June 27,	1931 Delaware
Maryland	tor	10a. State 10b. County Maryland Ceci		own or Location		10d. Inside City Limi 1 ☐ Yes 2 🏋 N
or 28a	Direc	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Country?
eath w	erai	37 Cambridge Ro	pad 12. Was Decedent Ever in U.S.	21921	acify Vas or No-	United States 14. Race - American Indian.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avent, the Modical Evantrer must be notified at ONCE.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 X Divorced	Armed Forces?	 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify: 	Rican, etc.)	Black, White
"natura	leted	15. Decedent (Specify only highes	's Education 1 t grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of work	ing 16	bb. Kind of Business/Industry
d withir giene. er than	Comp	Elementary/Secondary (0-12)	Coilege (1-4or 5+)	Homemaker		In Her Own Home
ntal Hy ed othe	Be	17. Father's Name (First, Middle, I			e (First, Middle, Ma	iden Sumame)
should nd Me n mark nmark	스	19a. Informant's Name/Relationsh		Emily S 19b. Mailing Address (Street and Number or Run		City or Town, State, Zip Code)
and 2 ealth a n 27 ls		Ann Marie Hobbs/		37 Cambridge Road, Elk		21921
ages 1 nt of H t: ff itar		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 □Removal from State ceme	etery, crematory or other place) Febru	uary 9,	c. Location - City or Town, State
permit. P. Departme Importani any injury		*4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service I		Ferris & Co., Inc. 2010 22. Name and Address of Facility Hicks Home for Fund 103 W. Stockton St	omolo D	West Chester, PA
8958		Buston		nicks nome for rune	erale P	Α .
Physician /Medical		23a. Part L Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Peripheral	103 W. Stockton St.	or respiratory arrest	Approximate Interval Between
/Medical Examiner	cal Examiner	shock or heart failure. List of Immediate Cause (Final disease or condition	complications that caused the death. During one cause on each line. a. Due to for as a consequent. b. Due to for as a consequent. c. Due to for as a consequent. d.	Do not enter the mode of dying, such as cardiac of the configuration of	or respiratory arrest	Approximate Interval Between Onset and Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEB. 10, 2010 Physician/ LEONARD WINTON HYDE 18:17P ^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CLINTON P.G. SOUTHERN MD.HOSP. CENTER Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign MD • 7. Age (In vrs. last birthday) Funeral Days 6-6-193 Months 1 JM 2 - F 78 218-26-6629 **Director** Usual Residence of Decedent 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important I fleem 27 is anarked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD. CHARLES LA PLATA 1 🗆 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5630 OWNA LANE 20646 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 XMarried Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates, U.S.A.F 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 Divorced 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NURSEYMAN SELF EMPLOYED 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ LOUIS SOUTHGATE HYDE MABEL A. DeLOZIER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEANETTE HYDE-SPOUSE 5630 OWNA LANE LA PLATA, MD. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1♥ Burial 2 □ Cremation 3 □ Removal from State Cemetery, crematory or other place)
4 □ Donation 5 □ Other (Specify) 2-17-2010WALDORF, MD. 21. Signature of Funeral Service Licensee Name and Address of Facility
AYMOND FUNERAL SERVICE, P.A.
A PLATA, MD. 20646 M00479 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. nter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Leiomyosarroma Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE; 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlyIng cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes 2 NO မ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physicians to the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Example 7: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying N edge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

DHMH 17 Rev 7/2009

041

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ George B. Hansel Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** E6 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🔀 M 2 🗆 F Min. (Month, Day, Year) ine 25, 1923 Months Hours 216-18-1613 Director 86 June Dakota Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1X☐ Yes 2 ☐ No MD Allegany Westernport 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 25801 Shady Lane, Apt. 332 21562 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. WWII White 1 ☐ Yes 2 🚾 No Specify: Specify: "natural", 3 X Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self-employed Excavation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Oscar Hansel Iva Elizabeth (Patterson) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13905 Cresap Mill Rd., SE, Oldtown, MD 21555 Gemma Schade Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Restlawn Memorial Gar Feb 12 2010 LaVale, MD . Signature of Funeral Service 22. Name and Address of Facility Hafer Funeral Service, P.A. 1302 National Hwy., LaVale, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Severe Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 Yes 2 No 1 Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Tyes မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 24 hours after death. Investigation Accident the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined filled in by 4 Homicide City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed within 2 3 only one

State

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ardalan Enkeshof

30. Name and address of person who completed cause of death (I)em 23a) (Type, Print)

12500 Willow brook

32, Registrar's Signature

roud

: Cumberland, MD

29d. Date signed (Month, Day, Year)

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Lee Dianna Henneberger 135 QM 01 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F Hours (Month, Day, Year July 18, 1 183-42-7093 58 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Examiner must be notified at Director PA Franklin Waynesboro 1 Yes 2 No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17268 314 Landis Avenue USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 9 þ 1 Never Married 2 X Married Black, White, etc 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify.White "natural", 3 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) customer relations rep. plastic fabrication Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Close Claire Ferguson other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas W Henneberger husband Landis Avenue, Waynesboro PA 17268 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite injury or 1 Durial 2 Cremation 3 X Removal from State Humanity Gifts Registry 02/8/2010 Philadelphia, PA 4 XDonation 5 Other (Specify) Signature of Funeral Service Dicenses Grove-Bowersox Funeral Home, Inc. 17268 law) 50 South Broad Street, Waynesboro PA 23a. Part /. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) as a consequence of) Due to (or **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exam or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events the burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year the Unknown detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 2 00 Completed 1 🗌 Yes 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 funeral director. 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 \(\text{Yes} 2 X No Certificate: To ER/Outpatient 3 DOA Inpatient 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred work? Natural 5 Pending Accident the Investigation Suicide Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) the Hospital Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month. Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JANUA STEVEN EUGENE HARVEY 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13003 VENANGO RD WASHINGTON PRINCE GEORGE Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗽 M 2 🗆 F Months Days Hours Min 3 Month Bag Year) WASHINGTON, DC Director 220-02-2582 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD PRINCE GEORGE FT. WASHINGTON 1 🏋 Yes 2 □ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 20744 U.S.A. 13003 VENANGO RD 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. ò 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: BLACK "natural", Completed 3 🗆 Widowed 4 😾 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. LANDSCAPING PRIVATE 12th Be permit. Page 1 and 2 should be filed a Department of Health and Mental Hyg Important: If item 27 Is marked othany injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည FLOYD HARVEY WILLOW V. HARVEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLOW V. HARVEY/MOTHER 13003 VENANGO RD FT. WASHINGTON, MD 20744 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) MOORE FAMILY CEMETERY 02/03/2010 | BLOUNTS CREEK, NC 21. Signature of Funeral Service Licens 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ teriose disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Dividito (or as a nonsequente of Hospital or Attending Physician. The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 as the IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death Month Day Year signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 certificate has performed 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred After iniury 1- Natural 5 \square Pending אר. s after dec. al Director: After 2 🗆 No Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29c. License numbe

29d. Date signed (Month. Day, Year)

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	uneral rector		5. Social Security N 579-84-5		6. Sex 1 🖾 M 2 🗆 F	7. Age	e (In yrs. Ia 49	st birthday) Yrs.	If Under 1 Months	Days	If Under 24 H Hours M		<i>ay, Ye</i> a	(r) Co	thplace (State or Foreign ountry) nington DC	n
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₹ 6 ≥	27 is er trau		Sheryl			fe)		221	Lakesi	ide_	Drive #		enb	elt MD 2	0770	
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Dallille permit. Page Department	ortant: Injury E.		4 ☐ Donation 21. Signatura of Fu				Her.	_	Park (_	2/4/10		ldorf, Ma	vices, P.A.	
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DIVISION OF VICE THE HOSPITAL OF ALL DOX 60 TOV, TO THE HOSPITAL OF Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	r the attending physician and ched for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 9 ☐ Unknown	! months? □ No		e birth egnant at	of pregnar 2 ☐ Fetal t time of de	death 3	☐ Ectopic pre☐ Other (spe					23d. Date of de Month	livery Day Year	
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Tott withi	To th	Ž	29b. Signature and	title of certifie	1	7		-	29c.	. License	e number	216	29d.	Date signed (Mon	th, Day, Year)	
	4		30. Name and add	ress of person	who completed ca	use of d	leath (Item	23a) (Type,	Print)	P	50	5/0		1/08/	10	
1	7		James da	ateveni	s, M.D.	30	01 Ho	spita	l Driv	æ,	Cheverl	Ly MD 207	785			
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Please Type or Print in Black Indelible Ink 25,72410 All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death asper Physician/ 1221 RN グめた Medical 4a. Facility Name (if not institution, give street and number, Location of Death Drince Georg Examiner they 1 Aton MO If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 16 254-60-Days Months Hours 1 🗆 M 2 Linton Yrs. **Director** Ga. Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I frem 27 is ansked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Prince George's District Heights 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 20747 United States 6411 Kipling Parkway 12. Was Decedent Ever in U.S. Armed Forces?

1 ፟ Yes 2 □ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) P.G. Public School 12 School Teacher Be 17, Father's Name (First, Middle, Last) 18. Mother's Ngna (First Middle, Maiden Surname) ဂ Matthew Turner, Jr. Romie Standford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6411 Kipling Parkway District Heights, MD 20747 <u>Cassandra Harper / Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specific 2/11/2010 Cheltenham, Maryland Maryland Veterans 22. Name and Address of FacilityPope Funeral Homes, P.A. Signature of Funeral Service Lice 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kalemia Physician/ disease or condition resulting in death) Medical Due to or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine requires that the death certificate be executed physician a s the burial-1 Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death by the a tached f 9 Unknown g Unknown P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by IVE Records, 3 Probably 4 Unknown 1 Yes 2 🗌 No peen 24b. Were autopsy findings available 24a Was an To the Hospital or Attending Physician: The law I within 24 hours after death.

To the Funeral Director: After this certificate has k completed filled in by the funeral director, page 2 s autopsy, perform prior to completion of cause of death? 2 No 1 Yes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 3 Other: ပု No 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 8b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending Division 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one title of certifie 29c. License number pause of death (Item 23a) Type, Print) person who completes State Registrar

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			For State Registrar	State of M	aryland		artmen tificate			and M		giene Reg. No.	010	046	599		
	Physicia		Decedent's Name (First, Middle, L CLEO HALI	•							2. Date of Dea Month January	Dav	2010	3. Time of D 9:45a	Death M		
	Medic Examin		4a. Facility Name (if not institution, gi	ve street and number)			1		Location o		o arraar	4c. Co	unty of Death				
	Funeral			Sex 7. Ag	e (In yrs. las	st birthday)	If Under	r 1 Year	lvil	24 Hrs.	8. Date of Birt	1	nce Ge	place (State or	Foreign		
	Director		248-40-6176 Usual Residence of Decedent	1 □ M 2 🛣 F	90	Yrs.	Months	Days	Hours	Min.	Oct 31,	^Y 1919	Cour	SC SC			
	rland f show dat	tor	10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City			
	r 28a-1 notifie	Director	MD Prince 10e. Street and Number	Georges	Mit	chell	ville					40- Citi-on	of What Cou	1 🗌 Yes :	2 % No		
	with th	Funeral	1300 Fairlakes l	21.				721					JSA	itry?			
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:							14. Race - American Indian, Black, White, etc. Specify: Black			
15-0	72 hou n "natu fedical	nplet	15. Decedent's (Specify only highest	grade completed)		16a. Deced	lent's Usua kind of wor O NOT use	rk done d	ation <i>Juring most</i>	of worki	ng	16b. Kind	of Business In	dustry			
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and	oe filed intal Hy ced oth c event	To Be	17. Father's Name (First, Middle, Last Isaac Oliver	")							e (First, Middle, i Orman	Maiden Suri	name)				
Maryland	should be filk h and Mental I 7 is marked o traumatic eve		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a			l Route Number	; City or Tov	vn, State, Zip	Code)			
	and 2 s Health tem 27	8 1	Sharon Walton – 20a. Method of Disposition	Daughter	20b Di	1300 ace of Dispo			s Pl.		itchelly						
mor	Page 1 nent of ant: If it		1 ☒ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		се	metery, cren	natory or o	ther plac	1		Date - 2010		ion - City or Ti .and, M				
Baltimore,	permit. F Departm Importa any inju once.		21. Signature of Funeral Service Lice								Home of						
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	Physician/		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line Alzheim		iseas	e							Interval Betw Onset and De Vears			
7	Medical Examiner		resulting in death)	Due to (or as Azotemi		ence of):								months			
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00	e be ex ysician ie buria	ical		d													
. Box 6876	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director. After this certificate has been signed by the attending physician and feuneral Director. After this certificate has been signed by the attending physician and ted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic p		у			230	. Date of deliv	•	ear		
, P.O.	es that the dec signed by the a be detached t		Part II. Other significant conditions	contributing to death b	out not resu	Iting in the u	nderlying (cause giv	en in Part I	l.				he cause of dea			
of Vital Records,	require been signal	Completed by	vi								24a. Was a			bably 4 K U			
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	Hospit 24 hour Funera eted fills	Medical	(Check 2, Medical Exa	nysician: To the best of miner: On the basis of e urse Practioner: To the	examination	and/or invest	tigation, in	my opinio	n, death oc	curred at	the time, date a	nd place, an	d due to the ca	use(s) and man	ner stated.		
	To the within 2	Σ	only one) 3 Certifying No. 29b. Signature and title of certifier	urse Practioner: 10 the	best of my	knowledge, c		. License		and plac			gned (Month,				
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R	7		30. Name and address of person who Millie Jarrell			23a) (Type, F Galla		x Lr	ъ. Во	owie	, Md. 2	0715					
	Sta Registra	te ar	31. Date (Month, Day, Year)	32. Registr	r's Q ignal	all!											

DHMH 17 Rev 7/2009

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Records, P.O. Box 68760,	The law requires that the death certificate be executed
Division of Vital	the Hospital or Attending Physician: T

	1	State Registrar			Certificate of	Death		eg. No. 20	10	0470
ician		1. Decedent's Name (First, Middle, L Helen Hume HANSE	,				2. Date of Deat Month Februa	Day Y	'ear	3. Time of Death 3. 27 p. M
dica line		4a. Facility Name (If not institution, g	give street and number)		4b. City, Town, or	r Location of Death		4c. County of		
		19 East Poplar S	Street		Funkst	own		Wash	ingto	n
Г			Sex 7. Ag	e (In yrs. last birthe	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace Country	e (State or Foreig
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	- 1	Usual Residence of Decedent		10c. City, Town of	or Location				104	Inside City Limits
>		10a. State 10b. County							700.	1 23 Yes 2 □ No
400	ีเ⊦		ington		Funkstown 10f. Zip Code			0g. Citizen of Wh	at Country'	
Ċ	5	10e. Street and Number			Tol. Zip Code	01707	Ι.		at Oountry	•
	5	19 East Poplar	12. Was Decedent	Ever in II S	13 Was Decedent of H	21734	ecify Ves or No-	USA 14 Bace	American	Indian
		11. Marital Status1	Armed Forces?		 Was Decedent of H If Yes, specify Cuba 	an, Mexican, Puerto	Rican, etc.)		White, etc.	maian,
	2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2X No	Specify:		Specify:	wh	ite
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	2	Samuel Scott Har	nsbrough			Dorothy	Stouff	er		
		19a. Informant's Name/Relationship	(Type. Print)	19b. N	Mailing Address (Street	and Number or Rui	al Route Number	r, City or Town, S	tate, Zîp Co	ode)
		Jim Hansbrough -	- brother	24	424 Scotch	Pine Trai	ll, Linc	oln, NE	68512	
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		21. Signature of Funeral Service Lic	ensee //		22. Name and Addre	ess of Facility M	NNICH F	UNERAL H	OME	
		coult	1/1/um	un	415 E.Wils	on Blvd.,	Hagers	town, Ma	rylan	d 21740
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month HOWELL Betty Jane 830 2010 JANKARG Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Y 215-26-1705 Mary Land Director 80 Yrs 1929 Oct. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director Maryland Washington Hagerstown 1 ☐ Yes 2🎛 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 118 Plantation Drive 21740 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white If Yes, Give Specify: Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working iife. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) labor Ice Cream, mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Fred R. Palmer Mary Ann Mayhue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31 Maplewood Court, Harpers Ferry, West Virginia Arthur L. Howell, Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Cedar Lawn Memorial 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) February 2010 | Hagerstown, Maryland Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on such line. Immediate Cause (Final Ph sician/ en disease or condition resulting in death) Medical Due to (or s a consequence of) Examiner NiON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) Yes 4 ☐ Pregnant
9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacço use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Matural V injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the l within 2 To the l only one) 29b. Signature and title of certifi 29c. License numbe 29d. Date signed (Month, Day, Year) 53519 SCK Name and SH-5

State Registrar 31. Date filed (Month, Day, Year)

FEB 0 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death

	1.
Physician	
/Medical	_
Examiner	4a
	Ι.

Funeral

or 28a-f show event, the Medical Examinar must be notified at or Items 23a

Maryland 21215-0036

Baltimore,

Box 68760,

P.0.

Division of Vital Records,

Physician /Medical Examiner

The law requires that the death certificate be executed the attending physicien sate has been signed by page 2 should be detac certificate or Attending Physician: this

Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Edward January 22, Harris, Sr. 2010 5:20 . Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Julia Manor Health Care Center Hagerstown Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 13, 5. Social Security Number Birthplace (State or Foreign Country) 157M 2□ F 218-24-2133 Director 1930 Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17 Yes 2 No Director Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1039 Florida Ave. 21740 U.S.A. Completed by Funeral 14. Race · American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: if them 27 is marked other than "natural, or item any njury or other traumatic event, the Medical Exempter 2008. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specity: Specify: White 3 ₩idowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Interior Elementary/Secondary (0-12) College (1-4or 5+) General Laborer 11 Building Products 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nettie Virginia Young Clarence William Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 Frederick St., Hagerstown, MD Steven Harris/ Son 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Rest Haven Cemetery 1/25/2010 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau e on each line. tmmediate Cause (Final disease or condition resulting in death) UNG Cance Due to (or as a consequence of): Imonary Di Sease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 No Certification: To Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Surring Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA within 24 hours after death,

To the Funeral Director: After thi
completely filled in by the funeral is 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2323 01-72-2010 5

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State Registrar

DHMH 17 Rev 1/2001

1126 Opal Ct., Hagerstown, MD 21742

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

32. Pégistrar's Signature

Muhammad Waseem MD

FEB 01

31. Date filed (Month

Physician /Medical Examiner

Funeral Director

	,	For State Registrar			f Marylar	nd / Depa		t of H	ealth a				201	0	04703	
sicia edic	_	1. Decedent's Nam		_{e, Last)} Mae Hard	ing						2. Date of De Month	ath 2 ^{Day}	20 [°]	i arO	3. Time of Death 6:50P M	
min	40			n, give street and nui rsing Ho			Bra	ddo	Location o	gts			County of cede:		k	
ral tor		5. Social Security N	5085	6. Sex 1 ☐ M 2 X F	7. Age (In yrs. 101	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birl 1 1 1 9	^b /19(08	. Birthpl Coun	ace (State or Foreign	
3	or	Usual Residence o 10a. State MD	10b. County	derick	10c. Cit	ty, Town or Lo	ocation 1idd1	eto	wn				·	10	0d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	I Director	10e. Street and Nu 2511	mber Bidle	Rd.			10f. Zip	Code 217	69			10g. Citiz	en of Wha	at Coun	try?	
	by Funeral	11. Marital Status 1 □ Never Mari 3 □ X Widowed		ied Armed Fo Tied 1 ☐ Yes If Yes, Gi	2[XNo ve		Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)		Black,	American Indian, White, etc. White		
	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) homemaker 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker OWI												home		
	To Be ((First, Middle, se Cru	,							(First, Middle, Dobbs		Surname)			
		19a. Informant's N Joan Ni		hip (Type. Print) (Daught		9 Pc	oache	er T	rai1	er or Rura B	al Route Numb erlin,	er, City or MD	218	ate, Zip 11	Code)	
			•	3 □ Removal from pecify)	State St	Place of Dispo cemetery, cre niths	osition (Nar matory or o	ne of therplace Cre	mato	_	^{Date} /28/20		nith			
ouce.		21. Signature of P	neal Service	Licensee	96V	/ at	Bona POB 1	d dddr <u>B</u>	s of Facility Midd	omp 1et	son Fu own, M	nera ID 2	а1 Н 1769	ome		
an		Part1. Enter sbock, or ea Immediate Cause disease or condition resulting in death)	(Final	a.	REUMO	NIN	ter the mod	e of dying	g, such as	cardiac (or respiratory a	rrest,		J.	Approximate Interval Between Onset and Death HDAYS	
er er	-		onditions,	b	(or as a consec		***								•	
	cal Examiner	Sequentially list or if any, leading to ir cause. Enter Und Cause (Disease or that initiated event resulting in death)	S	6 c	(or as a consec											
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	Complete	An	emia	_							24a. Was auto perfo 1□ Yes		1 dea	ath?	osy findings available npletion of cause of 2 \square	
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	Certific	3 ☐ Suicide 4 ☐ Homicide	6 □ Could determ	.: I Zoe. Place	of injury - At h ing, etc. <i>(Speci</i>	ome, farm, sti	reet, factory	, office			28f. Location (City or To			or Rura	l Route Number,	
	Medical Certification:	29a. Certifier (Check only one)	1 ☐ Certifyir 2 ☐ Medical	ng Physician: To the Examiner: On the b and man	e best of my kno asis of examina ner stated.	owledge, deat ation and/or ir	th occurred nvestigation	at the tin , in my o	ne, date a pinion, de	nd place, ath occur	and due to the red at the time,	cause(s) date and	and manr place, an	er as si d due to	ated. the cause(s)	
	James L. Coenler D20488 1-28-2010															
-				who completed cause			Print)	ct '	37.	Mir	D LETO	Nu	, W	D.	21769	
Sta istr	ar	31. Date filed (Mo	JAN2	9 2010 32. F	Registrar's Sign	ature .	barri	/								

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Registrar

VSH-5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Registrar Amend#7 Perfuneral home 2/2/10 coloff bate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 25° 2010° Adelino Henriques 8:35 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charles La Plata Civista Medical Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Nov 25, 2010 _68 Yrs. Hours Director 044-34-9062 59 Portugal Usual Residence of Decedent show 10a, State 10c. City, Town or Location "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10d. Inside City Limits Director Charles 1X Yes 2 No MD Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral US 20601 Peters Church Road 3251 St. 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ♠ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ō 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 ral Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home Builder Homes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H is marked of Amelia Jesus Agostinho Henriques 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau 3251 St. Peters Church Rd. Waldorf, MD 20601 Maria Gomes/Wife 20a. Method of Disposition

1 Durial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State St. Peters Catholic Church 1/29/10 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Linenses 22. Name and Address of Facility Huntt Funeral Home Kelli R.h 3035 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (o as a consequence of Examiner PSV Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequen e of): Examir and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Yes 2 No 9 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? হ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? this certificate 2 1 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred in 24 hours after death.

the Funeral Director: After inpleted filled in by the funer. Hospital or Attending 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F complet 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANTHAN 3328 OID WASHINGTON RD WALDOLF, MD. 20601

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Samue1 10 Anthony Iacona, Sr. 1600 M eloruan Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death ASTON albot HOSPITAL Memorial 1 Year If Under 24 Hrs Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Hours April 20,1945 Pennsylvania 64 205-34-0078 **Director** Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Important: If item 27 is marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified 1 🖵 Yes 2 🗆 No Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 900 Gay Street Apt. 21629 United States of 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married Yes 2 No 5-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Caucasian 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) be filed within and Mental Hygiene. Agriculture Farm worker Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bob Veeko Iacona Betsv Whitaker . Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah K. Iacona Wife 900 Gay Street, Apt. D, Denton, Maryland 21629 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department 2/12/2010 Dover, Delaware <u>Capitol Crematory</u> permit. I 21. Sonatur Funeral Service License 22. Name and Address of Facility Moore Funeral Home, P.A. Street, Denton, Maryland <u>South Second</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last igned by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate It 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 40 ပ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and addre State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State #15, FH, TCHD, 2/4/10, r1s Amended Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1740 JOHN S. IRELAND reloruary 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ASTON MLBO 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7, Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min. FEB. 1. 75 MARYLAND **Director** 214-32-5054 T935 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland at 10d. Inside City Limits Director or 28a-f sh notified 1 X Yes 2 No MARYLAND TALBOT EASTON 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 120 BOUNDARY LANE UNITED STATES 21601 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. by 1 Never Married 2 X Married 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates per it. Page 1 and 2 should 'e filed within 72 hour. De; artment of Health and Mental Hygiene. Important: If item 27 is mar ed other than "natur any injury or other traumati: event, the Medical one. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) RESIDENTIAL Elementary/Seconday (0-12) College (1-4 or 5+) 10 -6- CONTRACTOR CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 HERBERT IRELAND BESSIE COVEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN K. IRELAND/SON 24 WRIGHTSON AVE., EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Acremation 3 Removal from State CHESAPEAKE CREMATION CENTER 4 Donation 5 Other (Specify) FEB. 3, 2010 STEVENSVILLE, MD 21. Signature of Funeral Service License P.A. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 S. HARRISON ST., EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 5chemi Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or iinjury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 performed 2 7 1 Yes 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 **X**Vo ျပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural (Month, Day, Year) injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie сопріете (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one within To the 29b. Signature and title 29c. License number 29d. Date signed (Month. Day, Year) 54488 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

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219 gistrar's Signature Washington St

Easton UD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 4. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William S. Jones, Jr. February 2, Day 2010 10:30 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4704 Coachway Drive Rockville Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) July 29, 1929 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 XM 2 D F Pennsylvania **Director** 171-24-3280 80 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 🗆 Yes 🚈 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4704 Coachway Drive 20852 USA within 72 hours after death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates. 1951-59 3 → Widowed 4 □ Divorced Specify: Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) r and Mental Hygien Salesman Food Brokerage Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William S. Jones, Sr. Clara Virginia Springer 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie Owen/Daughter 219 Nashua Court, Gambrills, MD 21054 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Feb. 3 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death years Physician/ Coronary Artery Disease Medical resulting in death) Due to (or as a consequence of): Examiner Aortic Stenosis years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury Atrial Fibrillation year that initiated events resulting in death) Last and-trar Due to (or as a consequence of): physician a the burial-Physician/Medical Box 68760 ed by the attending I IF FEMALE: es, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò pe Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page performed? Yes 2 No 1 Yes 2 No **Division of Vital** 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: ပ္ 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred Natural (Month, Day, Year) iniury 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: / 3 ☐ Sulcide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Daniel

31. Date filed (Month, Day, Year)

Griffin, MD

15225 Shady Grove Road, #201, Rockville, MD 20850

son who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

D42110

February 3, 2010

				Please	Type or Pr							_	le.		
			For State Registrar		State of M	arylan		artment of <i>tificate of</i>	Health and	Mental Hy		dia		* 1	
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	e Mar r 28a- notifie	Direc	MD. 10e. Street and Nur	Harf	ord	White Hall 10f. Zip Code 10g							1 ☐ Yes 2 X		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	Funeral Director			lle Road	L	Toi. Zip Code		Dnited States						
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	121	ŀ	30. Name and agdre	ess of person who c	ompleted cause of d	eath (Item	23a) (Type, P	rint)	1.10			1010	- (
	Stat		JACKIE J 31. Date filed (Monti	ONES, CRI	P 2300 D	ULAN ar's Signat	EY VAL	LEY RD.	TIMONIU	M.MD_210	93				
312	Registra	C		FFR 19	2010 32. Registra	eren.	B. 1	PARKE							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				partment of Health and M Pertificate of Death	_	giene Reg. No. 2011	0 04709
	Dhysisi		1. Decedent's Name (First, Middle, Last)		2. Date of Dea	ath	3. Time of Death
	Physici /Medio	al	Samuel L. Johnson		Jan.	25 2010 2:00 p M	
and the same	Examin	er	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital	4b. City, Town, or Location of Death Laure1		4c. County of Death Prince Georges	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt	th 9. Bir	rthplace (State or Foreign
	Director		186-22-1526		5/18/19	928 Oak	mont, PA
	ryland how	_	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Ba-f s	Director	Maryland Prince Georges Forestvil				1 🗷 Yes 2 🗌 No
	with the		10e. Street and Number 2130 Brooks Dr. #408	10f. Zip Code 20747		10g. Citizen of What Co J nited Stat	
	ems 2;	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	B. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No		erican Indian,
36	s after ", or ite	by Fu	1 Never Married 2 Married 1	1 ☐ Yes 2 ☐ No Specify:	mean, etc.)	Specify: B1	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Ext. in or must be redilled at once.	ted	15. Decedent's Education 16a. De	cedent's Usual Occupation		16b. Kind of Business	/Industry
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/ar	2 short and the list ma		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3417 Grayvine Lane Bowie, MD 20721				
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<u> </u>	<u>7</u> 0 = ≅ 0		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate				
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Division of		Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)				
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	To the within ? To the comple	Mec	one) and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)
			M C M	D 24721	,	January 26,	2010
٤	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed Sadiq 14333 Laurel Bowie Rd. Ste. 208 Laurel, MD 20708				
ĺ	Store 31, Date filed (Month, Day, Year) 32, Registrar's Signature						
	Registr	ar	JAN 2 9 2010 Cenur . S. Sail				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** JOHNNIE JOHNSON January 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges 10401 Becky Ct. Clinton 5. Social Security Number Birthplace (State or Foreign Country) 6 Sev 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 ☐ M 2 🛣 F Director 99 July 2, 1910 246-10-4928 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination of the population and once. 1 Yes 2X No Director MD Prince Georges Clinton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 10401 Becky Ct. 20735 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 2 3 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: <u>م</u> Specify 3 X Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4+ Editor Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ unknown unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Foster - Daughter 4359 23rd Pl. Temple Hills, Md. 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1-21-2010 Suitland, Md. 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, Md. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hypertensive Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year Day 5 Other (specify) □Yes 2k No signed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been si page 2 should t 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No 24a Was an certificate 1 □Yes 2X No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 🛭 Residence 6 Other (Specify) Hospital: 1 Tes 2 XNo ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🛣 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

CR 5

State Registrar Cynthia Crawford-Green, MD 6196 Oxon Hill Rd.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

33. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ntha traw

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#500

1-26-2010

Oxon Hill, Md. 20745

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🔒 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month Physician/ /25/2010 12:45 PM ESTHER MAE JENKINS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GENESIS NURSING HOME WALDORF CHARLES Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country)
Campobello, SC If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2**X**□ F Months Days Hours Min 12/31/192 **Director** Yrs. 230-20**-**8953 86 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🏝 Yes 2 🗆 No NY Jamaica 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral United States 160-52 121st Ave 23079 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 Widowed 4 □ Divorced Specify: Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Be Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Alma Sims Millis Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once, Betty Ellis / Sister 7329 Cross Street District Heights, Maryland 20747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/30/2010 Laurel, Maryland <u>Maryland National</u> Signature of Funeral Service License 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Foresrville, Maryland 20747 23a. Part 1. Enter the diseased, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Onset and Death DAY Immediate Cause (Final Ph sician/ ACUTE MYOCARDIAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ARTERIOLOSCLEROTIC CARDIOVASCULAR DISEASE YEARS Securatelly list conditions if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last -tran and Due to (or as a consequence of): the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 💢 No Pregnant at time of death signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy performed? this certificate Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🛚 No 1 🗌 Yes Other 1 Inpatient 2 ER/Outpatient 3 DOA 4XX Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 1 🔀 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After t 28d. Describe how injury occurred injury 5 Pending ours after death.

leral Director: Ai
filled in by the fu 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours To the Funeral Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert 29d, Date signed (Month, Day, Year) D 18545 1/28/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Phillip Wisotsky 12070 Old Line Center Drive Waldorf, Maryland 20602 31. Date filed (Month, Day, Year) 32. Regist State JAN 2 9 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 6:25AM JOHNSON 2010 EMMA CATHERINE JANUARY 25, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** MONTGOMERY ROCKVILLE SHADY GROVE ADVENTIST HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 M 2 F Director Sept. 12 1926 Liberia 446-02-5748 83 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Maxical Exeminar must be notified at 1 KrYes 2 □ No Directo Gaithersburg Md. Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20882 Liberia 25010 Johnson Farm Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ∐Yes 2 🙀 No Specify. þ Specify: 3 Widowed 4 Divorced Black Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Education 12th Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental F Daniel Urey Armina Garnett ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun 25010 Johnson Farm Dr. Gaithersburg, Md. 20882 Darlingston Johnson / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-6-10 Silver Spring, Md. Gate of Heaven Cem. 21. Signal re Funeral Service Mensee 22. Name and Address of Facility Capitol Mortuary, Inc. Tomplications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, anly one cause on each line. Wash., DC 20002 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) **Physician** ARRHYTHMIA /Medical Due to (or as a consequence of): Examiner END STAGE RENAL DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consectionice of): requires that the death certificate be executed HISTORY OF GASTROINTESTINAL BLEEDING attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical HYPERTENSION IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 XNo Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) P.O. the signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐ Yes 2⊈ No this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 🔀 Natural To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □Yes 2 □ No hours after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatu title of certifier 29c. License number D005737 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#10g, perFH, G900, 2/25/2010, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2010 04713 Reg. No. 2. Date of Death 3. Time of Death $\overset{\mathsf{Day}}{1} \underline{0}$ Physician/ Harriet Kromah 2010 6:58 P M Jan Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 1680 Carlyle Drive #G Crofton 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. 12/10/1956 016-68-2693 Director 53 Liberia Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location death with the Maryland Examiner must be notified at 10d. Inside City Limits Director MD Anne Arundel Crofton 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1680 Carlyle Drive #G 21114 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ō þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 **Black** Yes, Give 1 Tes 2 K No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Merone. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Health Nursing Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ezekiel Massaquoi Geneveive Kromah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1680 Carlyle Dr., #G, Crofton MD 21114 Genevieve Morgan/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Geo. Washington Cem. 1/30/10 Adelphi, MD 22. Name and Address of Facility Capitol Mortuary Signature of Funeral Service Licensee Sharon Johnson-Salley per DVR 1425 Maryland Ave., NE Washington DC 20002 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, Hepatic Neoplasm disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit or Attending Physiclan: The law requires that the death certificate be executed Cause (Disease or in that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death should be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performed? Yes 2 No 2 No 1 Tes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗆 No 1 🗌 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) al Director. After the 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 🔼 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a filled Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

State Registrar

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29b. Signature and title of certifie

Enmussa C.

31. Date filed (Month, Day, Year) Registrar's Signature

SIAMUND 2835 SMITH AUMUE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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Bonsoiners, Mary has 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ 10:10a Μ. 2010 Kaufman Medical January 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12463 Woodsboro Pike Ladiesburg Frederick Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last hirthday) Funeral 1 🖾 M 2 🗆 F Months Days Hours (Month, Day, Country)
Maryland Yrs. Director ĭ931 214-28-5096 78 Usual Residence of Decedent or 28a-f shov 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No <u>Maryland</u> Frederick Ladiesburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 12463 Woodsboro Pike 21757 United States death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked any injury or other. þ 1 Never Married 2 X Married 1 ☐ Yes 2 K No Specify. Specify: Completed 3 ☐ Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Repair_Mar TV & Antenna Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Merhl David Kauffman Agnes Virginia Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Merhl Kaufman/ Son 6616 Granville Court, Frederick, Maryland 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2/3/2010 Cemetery Walkersville Maryland Signature of Juneral Service Lice 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes Pike. P. A. Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between acu Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an as S autonsy certificate ha perform death? Yes 2 N 1 Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident
Suicide
Homicide neral Director: A I filled in by the f Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical etrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of ce 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Flederick, MD 2170 skander, Elhamy MI 31. Date filed (Month, Day, Year) Registra 's Signature

DHMH 17 Rev 7/2009

State Registrar

Year

RS 15

State Registrar

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N BROADWAY, BALTIMORE, MD 21230 MICHAELA HIGGINS, JOHNS HOPKINS ENCOLOGY, 401 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Shawn Cherrise Hancock Knight January 20ĬÖ 9:00 A. 28, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1957 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 Months Days Hours December 22, 579-78-7495 52 Washington, D.C Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Prince Georges Temple Hills 1 X Yes 2 No Maryland 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 20748 4523 United States Akron Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. ò þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 N Divorced Specify: B1ack Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Paul Hastings, Janofsky I Hygiene. 3 College (1-4 or 5+) Elementary/Seconday (0-12) Legal Secretary & Walker Law Firm 12 should be filed wit alth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Theresa Roseanne Stevenson Robert Kenneth Hancock 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Lachaunteau Monique Knight-Biggins; 13000 Monroe Avenue; Fort Washington, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o Feb.5 cemetery, crematory or other place) ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lincoln Memorial Cemetery Suitland, Maryland Signature f uneral Servi / Licénsee 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner as the burial-transi and that initiated events resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 L Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a. Was an autopsy perform Yes Division of Vital 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner?

1 Yes 2 🗀 No Other: 1 Inpatient ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Director: Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a edical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the within 2

State 31. Date filed (Month, Day,

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death - Month Physician/ 9:24 AM 2010 Tanua Elizabeth Malinda Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington Hospital Washington County 9. Birthplace (State or Foreign Country) Maryland Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 1 □ M 2 🕱 F Min. (Month, Day, Director 1920 89 187-16-4582 Mav Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shot any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Marvland Washington 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral U.S.A. 21740 28 N. Mulberry St 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bender Ε. King Marv Leroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peppercorn Dr. Hagerstown, Maryland 21740 Schlotterbeck / Cousin Donna Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 2/1/2010_ Hagerstown, Maryland 21. Sign e of Fune S over e Lio 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, Maryland 2174 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final . Physician disease or condition resulting in death) 0 Medical Due to (or as a conseque of): Examiner V Maley Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed rsth use as the burial-transi eav. is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 menths?

1 Yes 2 No
9 Unknown Month Day Year Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 14 No မ 1 SInpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: - Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Y

J5H-2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. of the hard pobys m 6901 13/4/10 divental Hygiene D TIEM#8, 18, per INF 1901 3/2/10 10, ws Reg. No. State Registra Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Physician/ Elionora Leau AKA Eleonora Leau January 23 2010 201 Eleonora-Leau 2155 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 8. Date of Birth 10/27/19219. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 1 🗆 M 2 🔀 F Days Hours 1 dWood by Day Gears 88 Rowania Director 212-23-9627 Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Rockville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5800 Valerian Lane 20852 Romania within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Yes 2 X No "natural", or 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 Divorced White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2 should be filed with h and Mental Hygien 7 is marked other th Homemaker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grigore Budui Ecaterina Statescu Budui 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ecaterina Rauta (daughter) 5800 Valerian Ln/Rockville MD 20852 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Columbia Gardens 01/27/10 4 ☐ Donation 5 ☐ Other (Specify) Arlington VA Signature of Funeral Service Licensee 22. Name and Address of Facility Advent Funeral Services Annapolis MD and Falls Church VA 23a. Part 1. Enter the disease, or corty ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Anoxic Brain Injury Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner mes Cardiac amest Sequentially list conditions, Examine Due to for as a nonsequence off cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical pe レedu, E leon ord 01 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 ANo Day Month Year Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the Funeral Director: After this certificate has been signed appleted filled in by the funeral director, page 2 should be des 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires Completed Hematochezia 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Pneumonia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 1x No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After the Funeral Director After the Funeral Director of the Fune During administration of Natural 5 Pending 11:00 AM work? 1 ☐ Yes 2 🔀 No 12/31/09 Accident Investigation 6 Could not be anesthesia Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Suburban Hospital 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 8600 Old Georgetown Rd/Bethes a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D67986 01/24/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muneng Li, MD 8600 Old Georgetown Rd/Bethesda MD 20814 31. Date filed (Month, Day, Year) FEB 0 4 2010 2. Registrar's Signatur State ack Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Donald E. Lawver Feb. 5:20PM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery <u>Shady Grove Adventi</u>st Hospital Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Davs Hours Min. Director Pennsylvania 203-24-7602 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2√ No MD Montgomery <u>Germantown</u> 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20876 USA 20420 Boland Farm Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ູ່ 51**-** '54 3 Widowed 4 Divorced white Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry 5^{College (1-4 or 5+)} Elementary/Seconday (0-12) Medical Optometrist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown Dale F. Lawver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2520 Jasper Blvd Sullivans Island, SC 29482 Eric E. Lawver/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 02-05-2010 Biglerville, PA 4 ☐ Donation 5 ☐ Other (Specify) Biglerville Cem. . Sign. ure of Funeral Service. Licens 22. Name and Address of Facility 12525 Bradbury Avenue J. L. Davis Funeral Home Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician intraccrebral disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions Examine if any, leading to immediate cause. Lines Unidentifying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the bunal-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by history of coronary artery disease 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 💽 No မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

State Registrar

DHMH 17 Rev 7/2009

Medical

29a, Certifier

(Check

Dr. Huy

31. Date filed (Month,

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Re (istrar's Signature

Dic

🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Nguyen/9901 Medical Center Drive, Rockville, MD 20850

☐ Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MD69481

29d. Date signed (Month, Day, Year)

2010

Februar

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #29d per Phy G901 3/02/2010 Jh. State of Maryland Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEDYLLON Cindy Lewis Lou OID Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown 7. Age (In vrs. last hirthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Yea
Oct. 15, 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 🗆 M 2 🗓 F Months Days Hours 213-80-8619 Director 51 Oct. 1958 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Washington 1 Yes 2 No Hagerstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16102 McGregor Dr. 21740 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Maryland 21215-0036 nan "natural", o Medical Exam 1 Yes 2 X No Specify. 3 Widowed 4 X Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. City of Hagerstown Elementary/Seconday (0-12) College (1-4 or 5+) the Administrative Assistant Fire Department traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marlene G. Snyder Lynn Spielman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other transcence. Marlene G. Spielman/Mother 11530 Dellwyn Dr., Hagerstown, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖔 Burial 2 □ Cremation 3 □ Removal from State Rest Haven Cemetery 2/16/2010 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or compositions, or heart failure. List only one ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death .Physician/ nodo disease or condition resulting in death) Medical lue to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Ditto to (or as a consequence of Examir executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnapt 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Fetal death in the past 12 months? Pregnant at time of death Month Day ned by the a 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has l page 2 s autopsy perform certificate 1 Yes 2 No Yes 2 **Division of Vital** or Attending Physician; 25. Was case referred to medical funeral director, å 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 No Other: 은 Inpatient 2 ER/Outpatient 3 DQA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death nours after death.

neral Director: After the filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 29b Signature and title of certifier 29d. Date signed (Month, Day, Year)
February 12,2010 30. Name and address of person ed cause of death (Item 23a) (Type, Print) deric 4255 III 6 Allli 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

Registrar

21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Ma	arylana / i		cate of D		wieritai i iy	Reg. No.	2011	04721
	Physici	an	1. Decedent's Name (First, Middle, L						2. Date of De Month	Day		3. Time of Death
4	/Medic		4a. Facility Name (If not institution, gi	RENS W ve street and number)		4b.	Citv. Town. or	Location of Deati	MAC	Z Ĉ	County of Dear	
-	LAGIIIII		HOWARD COUNTY GO	INGLAL IT	PITAL		Cocum	SIA			HOWAR	9
	Funeral Director			Sex 7. Age 1 □ M 2 🔼 F	e (In yrs. last bii 85		Inder 1 Year oths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Mar. 9,	th ay, Year) 192	9. Bir Co	thplace (State or Foreign ountry) PA
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	e Mar Ba-f sl	Director	MD Carol		Sykesv	7ille						1 □Yes 2X No
	a or 2	Dire	10e. Street and Number			10	f. Zip Code	.,		•	izen of What Co	ountry?
	ms 23	Funeral	1711 Gemini Dr.	12. Was Decedent B	Ever in U.S.	13. Was E	2178 Decedent of His	34 spanic Origin? (S n, Mexican, Puert	pecify Yes or No		JSA 14. Race - Ame	erican Indian,
21215-0036	d within 72 hours after death with the Maryland giene. r than "natural", or items 23a or 28a-f show the Medical Expriner must be redified at	by	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	Armed Forces? 1	lo		, specify Cubai es 2.⊠No	n, Mexican, Puert Specify:	o Rican, etc.)		Specify: Whi	e, etc. ite
15-0	"natur	Completed	15. Decedent's E (Specify only highest g	ducation rade completed)	16a	(Give kind o	Usual Occupa	uring most of wor	king	16b. Ki	nd of Business	Industry (Industry
12	within iene.	omp	Elementary/Secondary (0-12)	College (1-4or 5		inte. DO Ne Homema	OT use retired) ker	,		Own	Home	
pu	Hy othe	Be C	17. Father's Name (First, Middle, Las	t)		10 moma		18. Mother's Nan	ne (First, Middle			
ylaı	2 should be f and Mental I is marked or aumatic eve	To I	Edwin Gensmier					Mary La	auver			_
Maryland	2 = 6		19a. Informant's Name/Relationship			_		and Number or Ru		-		Zip Code)
re,	s 1 and of Health item 27 other to		Tim Lawrenson - 20a. Method of Disposition	son			nini Dr (Name of or other place		Date Date		21/84 ocation - City or	Town, State
imo	Pages nent of ant: If its ury or o		1 ☐ ABurial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec				Nationa		5-2010	Suit	land, Mc	1.
Baltimore,	permit. Pages Department of Important: If ii any Injury or once.		21. Signature of Funeral Service Lice	ansee (Lu) oran	(1)	22. Nan Mar 430	ne and Addres shall s 8 Suitl	s of Facility Funeral	l Home o	of Ma	ryland MD. 207	46
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused one cause on each lin	the death. Do							Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Amy	IIC EN	CEPIH	HEUN A-	Tity				Onset and Death Z4 (FOVRS
1	/Medical Examiner		Tosuling in douting	,	a consequence	*	. Out and I	CAUSE				48 Hours
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	consequence	of).						10 HOVES
	ecuter and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last				ATION	Cipami	c Luna	7 00	SEASE	49 HOVES
68760,	sician burial		yourning in doubly state	Due to (or as a	a consequence	ot):						
687	rificate be executed ng physician and as the burial-transit	Medical										
Вох	death cer e attendin d for use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		3 □ Ecto	pic pregnancy			2	23d. Date of de	· ·
	0 0 0	Physician//	1 ☐ Yes 2 ☐No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 🗆 Othe	er (specify)				Month	Day Year
σ.	Attending Physician: The law requires that the de strong death. erdeath. by the threr this certificate has been signed by the a by the funeral director, page 2 should be detached to	by Ph	Part II. Other significant conditions	contributing to death bu	it not resulting in	n the underly	ing cause give	n in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
rds	w requires been sig should be	ed b	DEMENTIA	,					1 🗆	Yes 2[□No 3□P	robably 4 🔀 Unknown
ecc	e law re has be e 2 sho	Completed	CONGESTIVE IF	BART FA	LUAZ				24a. Was	psy	prior to	utopsy findings available completion of cause of
a	ding Physician: The h. After this certificate h funeral director, page		22.11						1 □ Yes		death?	2 2 2 2
Z.	ysicia is certi directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2 ☐ ER/Ou	utnatient 3.	DOA Othe	26. Place of Dea	ith <i>(Check only i</i> iome 5 ☐ Resi		6 DOther (Sec	noify)
n of	ding Phy J. After thi funeral o	T:UC	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day		Time of	28c. Injury Work		28d. Describe			city)
Siol	tendii leath. tor: A the fu	catic	2 Accident investigation 3 Suicide 6 Could not I	on .		М	1 🗆 Y	es 2□No				
=	I or Atten after deatl Director: I in by the	ertification: To	4 Homicide determined		ry - At home, fa . <i>(Specify)</i>	rm, street, fa	ctory, office		28f. Location (City or To	Street an wn, State	d Number or R	ural Route Number,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of	examination ar	e, death occu	urred at the tim ation, in my op	ne, date and place pinion, death occu	and due to the arred at the time	cause(s)) and manner a d place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner sta	ted.		29c, License				te signed (Mont	
	F > F 0		Develly	mym			036	974			N 21	
0	,		30. Name and address of person who	completed cause of de				0 6				
14	~		DAV(O U. NYANJUN 31. Date filed (Month, Day, Year)		r's Signature	ER DR.	Colun	SIA M	0.5104	+		
	Sta Registra		JAN 2 9 2010		La M	1						

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Donald Mark I	/lad	gett 1- For State	S	tate of Maryla	nd / Dep	partment of	Health and Men	tal Hy	/giene	ible.	
Physic	rian	Registrar 1. Decedent	s Name (First, Mid	dle Last)		ertificate of	Death		Reg	No. 201	J 04/22
Medical Exar		er.	bnald	Mark	Mad	gett II	L		2. Date of Death Month February 11	Day Year , 2010	3. Time of Death 0351 hrs
				on, give street and nun Medical Center	nber)	J 4t	. City, Town, or Location Salisbury	of Death		4c. County of Dea	th
Funera Directo		5. Social Sec	curity Number	6. Sex	7. Age (In yrs	. last birthday)		er 24Hrs.	8. Date of Birth(MM/DD/YYYY) 9 B	irthplace (State or
Directo		Usual Reside	9-1017 ence of Decedent	1⊠M 2∏F	4	Yrs.	Months Days Hours	Min.	1-25-1	91-3 Fore	ountry) LA
ow any		10a. State	10b. County	1 .	10c. Cit	y, Town or Location					10d. Inside City Limits
Maryland 28a-f show	Director	10e. Street a		mac K		hincote	GQUE Of, Zip Code		1100	Citizen of What Co	1 Yes 2 No
215-0036 be filed within 72 hours after death with the Maryland nna! Hygiene. The Other Ham "matural", or items 23a or 28a-f shorth, the Medical Examiner must he norified at once	غُ ا		Main	Street			23331		l log.	U.S.A	unu y ?
eath with the liens 23a or	uneral	11. Marital St 1 Never		12. Was Dece	ces?		Decedent of Hispanic Original Specify Cuban, Mexican,	gin? (Spe , Puerto F	ecify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
after d	by F.	3 Widow		orced If Yes, Give Year or Dates:	2 🔀 No	1 Y	es 2 No specify:			Specify:	hitz
2 hours "natur	ted	15. Deceder	nt's Education (Sper /Secondary (0-12)	cify only highest grade		16a. Decedent's during most	Usual Occupation (Give I of working life, DO NOT	kind of wo	ork done 16	6b. Kind of Business	/Industry
5-0036 led within 7 Hygiene. lother than	Completed			2	, G, 3+)	Inn	Keeper)	island m	and House
21215-00; uld be filed with Mental Hygiene, marked other ti	Be Co	1).	lame (First, Middle	Last)	1		18.Mother	1	First, Middle, Maid		116 110032
Med Me	TO B	19a. Informan	t's Name/Relations	hip (Type, Print)	adget	19b. Mailing A	ddress (Street and Num	ber or Ru	ral Route Number	SUTTON State	Zin Code)
MC salth au and 27 raums		Hnnc 20a. Method o	Loma	x 15157	1004	a653	Beech C	irela	Long	mont,	10 80503
nore ages lant of H		1 Burial	2 Cremation	3 Removal from	State	crematory or other		- 1		c. Location - City or	. 0
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other ti		4 Donation 21. Signature	of Funeral Service		100	Cchannoc 22. Nam	e and Address of Facility	9	14/2010	Lincotegg	
Physician			anda ter the disease, or	C - Botto	ed the death	Sal	yer funzíal	Hon	or Inc.	1327 /4	rurch St.
/Medical Examiner		14.70, 27	st only one cause use (Final disease	on each line.			vascular dis			shock, or heart	Approximate Interval Between Onset and Death
Ladillie			sulting in death)	Due to (or as a co			vaccarar are	case			
	ner	Sequentially lift any, leading		b	nsequence o	of):					
d sit	Examiner	(Disease or inj	ury that initiated ig in death) Last	c. Due to (or as a co	nsequence o	ıf):					
e executed cian and nial - transit	dical E	X UNPEN	DED.	d.							
O '0 '2 3	Medi	IF FEMALE:		AMENDED 23	a,27,p	permE, g9	00 2/25/10 1	T	12	22d Date of daling	
ox 68760 ath certificate b attending physicate but use as the but	cian/Me	23b. Was deced past 12 mo	dent pregnant in the inths?	1 Live birth		2 Fetal o		oregnancy		23d. Date of delivery Month D	ay Year
Box he death c	Physi	1 Yes 2		own 9 Unknown		□ Other	(Specify)				
lecords, P.O. Box 6876(The law requires that the death certificate ate has been signed by the attending physage 2 should be detached for use as the b	ģ	Part II. Other s	ignificant condition	ons contributing to de	ath but not re	sulting in the unde	lying cause given in Part	L		o use contribute to t	he cause of death?
ords,	oletec								24a. Was an	24b. Were aut	opsy findings available
Dr C 0 0	Completed								autopsy performed' 1 ✓ Yes 2		ompletion of cause of 2 No
n of Vital I ding Physician: h. After this ceriff	o Be	examiner?	eferred to medical	Hospital: 1 long	tient 2 🗸	ER/Outpatient 3	26 Place of Death (C				
Ing Phy		1 Yes 27. Manner of D 1 X Natural	2 No	28a. Date of Ir (Month, Day	njury	28b. Time of Injury	28c. Injury at Work?		ome 5 Resid		
isior Attend r death. ector: by the i	catio	2 Acciden	5 Pendii Invest	ng gation			1 Yes 2 N				
Division To the Hospital or Attent Within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 4 Homicid	determ		injury - At no	ime, farm, street, fai	ctory, office building, etc.	28f	Location (Street or Town, State)	and Number or Rura	al Route Number, City
he Hosp in 24 ho he Func pletely f		29a. Certifier 1 (Check only 1	Certifying Phy	sician: To the best of	my knowledg	e, death occurred a	t the time, date and place	, and due	to the cause(s) a	nd manner as stated	i.
To the within To the comple	Medical	1	Medical Exam	and manner state	amination an	id/or investigation, i	n my opinion, death occur 29c. License number	rred at the			
		/ /O	work	rus)			O.C.M.E.		[_	Date signed (Mont. bruary 12, 2010	
	1	Name and a		ho completed cause of sistant Medical Ex			and Delt'	0.455			
		31. Date filed (M	onth, Day, Year)		caminer ar's Signatur		eet, Baltimore, MD	21201	<u></u>		
Regist	rar		FER 16	2010 1 8		4 /					

DHMH 17 Rev 1/2001

0G: 3

OPIGINAL

10-010	88
Neal J.	Mclaughlin

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Amend State of Maryland & Department of Health and Mental Hygienger

		1- For State Registrar		Ce	ertificate o	f beath?	,,,,,,	7072	OTOGIII	Reg. No	D.		
Physic	ian	Decedent's Name (First, Midd	dle,Last)					1	2. Date of D	eath			3. Time of Death
Medical Exan	ine	Neil John McLau	ıghlin						Month Februar	Day 6, 20	Year 10		1338 hrs
		4a. Facility Name (if not institution		umber)		4b. City, Town, o	r Location	of Death		4	c. County of	Death	
		8241 Stephen Decati	ur Hwy #5			Berlin					Worceste	r	
Funera		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea			8. Date of I	Birth(MN			place (State or
Directo	1	170-52-4883	1 X M 2 F	49	Yrs	Months Day	ys Hours	s Min.	06/11,	60	ľ	Foreign Cou	ntry) CA
	7	Usual Residence of Decedent											
w any		10a. State 10b. County		10c. City	, Town or Locat	ion	-	-				- 1	10d. Inside City Limits
Maryland 28a-f show d at once,	5	MD Worce	ster	Ber1	in								1 Yes 2 X No
Maryl 28a-i d at o	Director	10e Street and Number 8241 Stephen	Decatur H	ww #5		10f. Zip Code				10g. Ci	tizen of What	Count	ry?
ith the 1 23a or notifie	🗟		catur Rd.	., .,		21811			1	USA			
72 hours after death with the Maryland "n"natural", or items 23a or 28a-f she all Examiner must be notified at once	Funeral	11. Marital Status	12. Was Dec	edent Ever in U		s Decedent of Hi	spanic Orig	gin? (Spe	cify Yes or N		14. Race - /	America	an Indian, Black,
death wi or items	Š	1 Never Married 2 M	larried Armed Fo	2 X No	If Y	es, specify Cubar	n, Mexican,	, Puerto R	ican, etc.)		White, 6	etc.	
after 'sl'',	ķ	3 Widowed 4 X Div	orced If Yes, Give Yea	r	1	Yes 2X No	specify:				Specify: W	hit	e
nours natur	Pa	15. Decedent's Education (Spe	cify only highest grad	de completed)	16a. Deceder	t's Usual Occupa ost of working life	tion (Give I	kind of wo	rk done	16b.	Kind of Busin	ess/Ind	dustry
16 n 72 isan "	Completed	Elementary/Secondary (0-12)	College (1	-4 or 5+)		g, Venti			۵)	He	ating,	Ve	ntilation
within iene.	ĮĔ	12			None	Air Co	nditi	oning	3		A/A& A	ir (Conditioning
215-003(be filed within mal Hygiene. rked other tha	ပိ	17. Father's Name (First, Middle, Hugh McLaughli Hugh McLaughlin	n Sr				18.Mother	's Name (F	irst, Middle	Maider	Surname)		
21215-0036 uld be filed within 72 hours after Mental Hygievier marked other than "natural", event, the Medical Examiner.	o Be	Hugh Melaughlin	, Sr.				Ella	Rutl	n Plum	mer			
D 2 shoul and N 7 is m	۲	19a. Informant's Name/Relations				Address (Stree							Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner myst be notified at once.		Ella Hanshew (20a Method of Disposition	sister)	206	2075 N	filford tion (Name of cer	Sq.Pk	Qua	kerto	wn,	PA 18	<u>951</u>	
Ore es la of Hi If it		1 Burial 2 X Cremation	3 Removal fro	om State	crematory or oth	tion (Name of cei ier place)	metery,		Date	20c.	Location - Ci	ty or To	own, State
im Page ment tant:		4 Donation 5 Other Sp		Car	e Henlo	pen Cre	m.	2/10/	2010	Fra	nkfor	d. 1)E
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within. Department of Health and Mental Hygiene. Important: If item 2: is marked other than injury or other traumatic event, the Medice		21. Signature of Funeral Service	Licensee		22. N	ame and Address	s of Facility	The I	Burbag	e Fı	ıneral	Hor	ne.
	_	1 spice / Am	son		1100) WIIII	m or.	beri	T T1 . IVI	1) /	IXII		
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	complications that ca on each line.	sused the death	. Do not enter th	e mode of dying,	such as ca	ardiac or re	espiratory ar	rest, sho	ock, or heart		Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease			<u>.</u> .								Death
		or condition resulting in death)	Due to (or as a	consequence o	f):								
	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence o	f)·								
	nin	cause. Enter Underlying Cause	c.	consequence o	17.								
d d	Examine	events resulting in death) Last	Due to (or as a	consequence o	f):								
xecuted	la E		d	t ner	। ೧<u>०</u>० च	3.31.10	-10-10-						
60, e be exe ysician	n/Medical	X UNPENDED	X AMENDED 2	23a,27,	28a-f.p	ermE, g9	00 2/	/22/1	0 тт				
8760, tificate being physic	Σ	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, o	utcome of pregr	nancy					230	d. Date of del	ivery	
x 687 th certific ttending p	ciar	past 12 months?	I Live bi	rth int at time of de	ath	al death 3	Ectopic	pregnancy	1		Month	Day	Year
Box 68 he death certif	Physicia	1 Yes 2 No 9 Unk	nown 9 Unknow		ath 5 Oth	er (Specify)				1			
that the ned by the detached		Part II. Other significant conditi	ons contributing to	death but not re	sulting in the ur	derlying cause g	iven in Part	t I.	23e. Did t	obacco	use contribute	e to the	cause of death?
res that the signed by it is detaction	ş								1 Ye	s 2	No 3 1	Probab	ly 4 🗸 Unknown
Division of Vital Records, P.O. Box 68760, tall or Attending Physician: The law requires that the death certificate be executed rs after death. at Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transi	Completed								24a. Was				sy findings available
COT law has t	힏								autor			to com	pletion of cause of
tal Reco	ड़ि								1 Yes				2 No
tal ician: certifi	Be	25. Was case referred to medical examiner?	Hospital: 4 In				of Death (C	Check only	one)				
of Vi ing Physi After this uneral dir	P	1 Yes 2 No			ER/Outpatient				ome 5	Reside	nce 6 🗸 O	ther: So	cene
n of ding Ph	ᇹ	27. Manner of Death 1 Natural 5 Pendi		f Injury Day,Year)	28b. Time of Inj		y at Work?	67	d. Describe thiect		ry occurred posed	to	cold
Sion Attend r death ector: by the	äŧ	= J Penal	tigation Fd 2/6		Fd 1:38	pm -	es 2XN	ar			mperat		
Divis	ertification		not be			factory, office bu	uilding, etc.	281	Location (Street ar	24 Yumber or	Rural	Route Number, City en Decatur
Division ospital or Attent hours after death neral Director:		4 Homicide determ	(0,000)	House				H ₇	vy, #5	, B	erlin,	M	
H H Fr	ၓ၂	(Check only one) 2 Medical Exam	ysician: To the best	of my knowledg	e, death occurre	d at the time, dat	te and place	e, and due	to the caus	e(s) and	d manner as s	stated.	
To the within To the comple	Medi	29b. Signature and title of certifier	and manner sta	ted	Twestigation			urred at the	e time, date				
	-	200. Signature and title of certifier		-	1 -	29c. License				ļ	ate signed (Day, Year)
	Ĺ	1hll1	111	1/		O.C.M	/I.E.			Febr	uary 8, 20	10	
}		30 Name and address of person v			('					•	_		
			ssistant Medica			Street, Baltir	more, Mi	D 21201					
St Regist	ate	31. Date filed (Month, Day, Year)	2010 32 509	istrar's Signatur	S. Jan	Kel					-		
1.00101			1000		- 11								

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amend #10e Per FH G900 2/24/2010 III
State of Maryland / Department of Health and Mental Hygiene

			1- State State Certificate of Certif	
			1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
€.,	Physici /Medi		Rolling II. Hellandi, of.	FEB. 09, 2010 8:21A M
	Examir		4. E-19. Non- Work had a factor of a first factor of the first factor of the first factor of the fac	or Location of Death 4c. County of Death
			Envoy of Denton Dent	
ì.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	Hours Min. (Month, Day, Year) Country)
	Director		Usual Residence of Decedent	June 29, 1918 Delaware
	yland yland		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	e Mar la-f sl	ctor	MD Caroline Federals	burg 1 □ Yes 2 🖾 No
	or 28	Dire	10e, Street and Number 10f. Zip Code 4 L 7 5	10g. Citizen of What Country?
	ath w	ral	2 4174 Seippes Road 2	1632 United States
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depardrment of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy hijury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral Director	3 ☑ Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 □ No	Hispanic Origin? (Specify Yes or No- pan, Mexican, Puerto Rican, etc.) Specify: 14. Race - American Indian, Black, White, etc. Specify: White
5	72 h "natu dical	etec	15. Decedent's Education 16a. Decedent's Usual Occup (Specify only highest grade completed) (Give kind of work done life. DO NOT use retire	pation 16b. Kind of Business/Industry during most of working
7	within ene. than	To Be Completed	Elementary/Secondary (0-12) College (1-4or 5+) Truck Drive	'
р 2	filed Hygid Sther Sint, the	ပိ	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
au	ild be f lental } ked ol	o B	Roland Henry McMahan, Sr.	Mildred Satterfield
ary	shou and N s mar umat	_		t and Number or Rural Route Number, City or Town, State, Zip Code)
Σ,	and 2 ealth n 27 i			es Road, Federalsburg, MD 21632
Baltimore,	Pages 1 ment of He ant: If iten jury or oth		20a. Method of Disposition 1	ans 02/16/10 Hurlock, Maryland
Ball	permit. Depart Import any Inj		21. Signature of Funeral Service Licensee 22. Name and Address 216 N. Ma:	ess of Facility Framptom Funeral Home, P.A. in St., Federalsburg, MD 21632
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.	Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. PROBABLE MYDCA	ARDIAL NEARCTION MINUTES
1	/Medical Examiner		Due to (or as a consequence of):	
Ю	- P	ē		10 VASCULAR VISEASE YEARS
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	
o Ô	icate be executed physician and s the burial-transit		Due to (or as a consequence of):	
68760,	ate be nysici he bu	edical	d	
õ ×	ertifica ing pl e as t			
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/⊪	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ 9 ☐ Unknown	23d. Date of delivery Month Day Year
ω, J	w requires that been signed b should be deta	by P		ven in Part I. 23e. Did tobacco use contribute to the cause of death?
ğ	equire en siç ould b	ed	HYPORCHOLESTOROLEMIA, DIABETES	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Records,	ne law ru has be je 2 sh	Completed	ISCHEMIC CALDIOMYODATHY, DEWE	24a. Was an autopsy findings available prior to completion of cause of
	(0 12	Con	PRIDE MYDEARDIAL INFARCTION	performed? death? 1 Yes 2 No 1 Yes 2 No
VItal	Physician; this certific ral director,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)
ō	this aldi	2	1 Inpatient 2 EH/Outpatient 3 DOA 5.11	4 Nursing Home 5 LI Residence 6 LIOther (Specify)
0	ding h. : After fune	tion	28a. Date of Injury 154 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 48b. Time of Injury 1 Injury 1 Injury	ry at tk? 28d. Describe how injury occurred rk? 1/9s 2 □No
JIVISION	I or Attending after death. Director: After I in by the funer	fica	3 Suicide 6 Could not be determined	28f. Location (Street and Number or Rural Route Number,
5	al or	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or Town, State)
		Medical (me, date and place, and due to the cause(s) and manner as stated. opinion, death occurred at the time, date and place, and due to the cause(s)
	Voithi Voithi Com	Ž	29b. Signature and title of conffigure 29c. Licens	se number 29d. Date signed (Month, Day, Year)
			THE MAKES ATTENDING MD DC	1053074 2-09-2010
				NGDALS AUE FEDSEALSBUZG, MID
ľ	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day_ Physician , 2010 Dolores Elizabeth Meyers February /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Caroline Denton Caroline Nursing Home, Inc. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 5, 1926 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Country) Maryland 1 □ M 2 □ F 83 July **Director** 212-22-7687 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lojury or other traumatic event, the Medical Examinat must be rotified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 TNo Director Marydel Caroline Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21649 17639 Henderson Road United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ 3 ₩ Widowed 4 Divorced Caucasian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **Broglie** ည Sipes Frieda John 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17639 Henderson Road, Marydel, Maryland 21649 Leslie A. Meyers 20b. Place of Disposition (Name of cemetery, crematory or other place Mary Land, Fastern Shore Veterans 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/10/2010 Hurlock, Maryland 4 Donation 5 DOther (Specify) Signature of Funeral Service Lice 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 Approximate Interval Between Onset and Death 23a. Part1. Enter the diseate, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. myocardial intarction Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** artery disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To 27. Manual of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 TYes 2 □ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number OW 00053255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ednum Ave Proston MD 21655 melin da 136 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Amended #1 1- State Registrar MD, TCHD, 2/2/10, rls Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** CONCHITA K. MORRIS Conchita (AKA Connie)K. Morris JANUARY 28, 2010 1316 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MEMORIAL HOSPITAL EASTON TALBOT 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 2/2/1934 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗙 F Yrs. 220-28-1374 75 MARYLAND Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f ehov other treumatic event, the Madical Examiner must be nutified at 1 ☐ Yes 2 ▼ No Director TALBOT EASTON 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number death with or Iteme 23a or 21601 30411 MATTHEWSTOWN ROAD USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 Ie marked other then "natural", or Itel 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM KNOX ELIZABETH MARSHALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LLOYD MORRIS/SON 1114 SPY GLASS DRIVE, ARNOLD, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ö Department of Important: If any Injury or once. CHESAPEAKE CREMATION 2/3/2010 STEVENSVILLE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. NOHN R. MERCERON 200 SOUTH HARRISON STREET, EASTON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 140CARDIA 15 min Physician INFARITION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ page 2 should be 4. Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available pnor to completion of cause of death? 24a Wasan 20 No 1 Yes 2 No 1□ Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ➤ R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 X Yes 2 □ No lhis After this funeral c 28c. Injury at Work? 28a. Date of Injury (Month, Day Year, 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Tyes 2 No within 24 hours after death. To the Funaral Director: A investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ۾ 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

completely

es 5

State Registrar 23.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of pertifier

MD 32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 18 per FH G900 2/19/10 dk

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lawrence Edward McCloskey Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Allegany Western Maryland Regional Med. Ctr. Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 29, 9. Birthplace (State or Foreign **Funeral** Hours Min. X M 2 D F 201-32-8428 68 Yrs Director Pennsylvania Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertial Hygiene. Important: If item 27 is marked of ther than "natural", or items 23a or 28a-f sho amortant: If item 27 is marked of the than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 X No Allegany MD LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1148-1/2 Braddock Rd 21502 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1958 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 1961 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12College (1-4 or 5+) Installer / Repairman Phone Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ (Unknown)-Conrad Earl McCloskey, Sr. Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Timber Ridge Rd., LaVale, MD 21502 Son Brian McCloskey 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 DeBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rockey Gap Vet Cem Feb 16 2010 Flintstone, MD 22. Name and Address of Facility Hafer Funeral Service, P.A. 21. Signature of Funeral Service License 1302 National Hwy., LaVale, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Heute disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Discare Covona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequent of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Ves 2 After this certificate has page 2 25. Was case referred to medical examiner?

1 \sum Yes 2 \sum No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 1-Natural injury 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar only one)

31. Date filed (Month

3 🗌 29b. Signature and title of cert

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009 40

Dic

To the I within 2 To the I

strar's Signature

29c. License number

Do0 33280

Cumberland, MD

29d, Date signed (Month, Dav. Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04728 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0600 Cecil May Bernard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland WMHS-RMC 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Date of Birth Funeral Country) MD 1 □ M 2 □ F Month Day 4ear) 1929 214-28-6440 Director 80 Usual Residence of Decedent items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Allegany Oldtown MD 1 Yes 2 XNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21555 USA P. O. Box 26 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces à 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give white Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Hartford Co. College custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nina (Teeter) May Edward May 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip P.O. Box 26 Oldtown 19a. Informant's Name/Relationship (Type, Print) MD 21555 wife Linda Mav 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 2/5/2010 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Full Full Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) HemoChromato Medical Due to (or as a consequence of): Examiner Sequentially list conditions. is any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed Atria the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Other (specify) After this certificate has been signed by the structor, page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 🗷 Natural 1 ☐ Yes 2 ☐ No Acciden Accident Investigation Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours are To the Funeral Dir Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar 12500

millowhrook

Rood

Cumberland ND

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

Ardulan Enkeshart

31 Date filed (Mo

10-00994	
Robert Alan	McDaniel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 04729 State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar		Certific	ate of	Death			Reg. No.	
Physician/ Medical Examiner		Alan M	[cDaniel				2. Date of De Month February	eath Day Yea / 3, 2010	3. Time of Death 0000 hrs
	4a. Facility Name (if not institution Anne Arundel Medical		or)	4	o. City, Town, or Glen Burnie		ath	4c. County Anne Ar	
Funeral Director	5. Social Security Number 217–11–3602	6. Sex 7. A	ige (In yrs. last biri	thday) Yrs.	If Under 1 Year Months Days			18,1973	7) 9. Birthplace (State or Foreign CountryWashingto DC
the Maryland a or 28a-f show any diffed at once, Director	Usual Residence of Decedent 10a. State 10b. County Maryland Princ 10e. Street and Number 15618 Main		10c. City, Town		n 10f. Zip Code 2060)7		10g. Citizen of Wr	10d. Inside City Limits 1 Yes 2 XX No nat Country?
s after death with rral", or items 23 niner must be no by Funeral	11. Marital Status 1 XXNever Married 2 M 3 Widowed 4 Div	orced If Yes, Give Year or Dates:	S? 2 No 2 No 2 No 2 No 3 No 3 No	1f Ye	s, specify Cuban Yes 2 Y No S Usual Occupati	, Mexican, Pue specify: ion (Give kind o	of work done		- American Indian, Black, a, etc. White
5-0036 ed within 72 hour 14ygiene. other than "natu the Medical Exam Completed	Elementary/Secondary (0-12)	College (1-4 o	r 5+)		st of working life.	DO NOT use r	etired)	Home :	Improvement
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than marked other than or over than or o	John	McDaniel				Je	eanette	, Maiden Sumame	Crooke
MD 21 d 2 should lith and Me n 27 is ma n unatic ev		iel – Father	15	5618	Main Blv	d A	Accokeek	, MD 20	
Baltimore, MD 21215-0036 permit. Pages i and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other that injury or other traumatic event, the Mestron To Be Compl	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Sp	pecify:	tate cremat Lee (ory or othe Crema	tory	Fel		O Clint	
	21. Signature of Funeral Service	nowe	01555	663	me and Address 3 01d A1	exandr:	ia Ferry	ral Home Rd, Cli	nton, MD 20735
Physician /Medical Examiner	failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	ug (coca	aine,	methado				Between Onset and Death
	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con		LUXI					
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a con:			 -				
7760, ficate be executed g physician and the burial - transit	X UNPENDED	d AMENDED	27.00	-		001 2/	0/10 ===		
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and applietly filled in by the funeral director, page 2 should be detached for use as the burial - transitical Certification: To Be Completed by Physician/Medical Eilical Certification:	IF FEMALE: 23b. Was decedent pregnant in th past 12 months? 1 Yes 2 No 9 Unk	23c. If yes, outcome 1 Live birth	3a,27,28a ome of pregnancy of time of death	Feta				23d. Date of Month	delivery Day Year
ires that the signed by I be detach	Part II. Other significant conditi	ons contributing to dea	th but not resulting	g in the un	derlying cause gi	iven in Part I.			bute to the cause of death? Probably 4 V Unknown
Division of Vital Records, ta or Attending Physician: The law requires rs after death. The Director: After this certificate has been signed in by the funeral director, page 2 should be extification: To Be Completed	25 Was case referred to medical	T			26 Place	of Death (Chec	1 Yes	ppsy pormed? d	Vere autopsy findings available rior to completion of cause of leath? Yes 2 No
Vital Invision: This certiff I director,	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpati	ent 2 🗸 ER/O	utpatient		Othor: □	sing Home 5	Residence 6	Other:
on of Vending Ph. ath. r: After tl he funeral	27. Manner of Death 1 Natural 5 Pend		Year)	Time of Inju	10 v	y at Work? es 2 X No	28d. Describe	how injury occurre	ed
Division o spital or Attending owurs after death neval Director: Afte filled in by the fune Certification:	3 Suicide 6 X Could	28e. Place of I	njury - At home, fa found at	ırm, street,		ulding, etc.		State)213 A	er or Rural Route Number, City Poplar Ave
To the Hospital within 24 hours To the Euneral completely filled	,	ysician: To the best of n niner:On the basis of exa and manner stated	amination and/or in						
Me is a	29b. Signature and title of certifie		_		29c. License			29d. Date signe February 4,	ed (Month, Day, Year) , 2010
	30 Name and address of person Donna M. Vincenti, MI			111 F	Penn Street,	Baltimore,	MD 21201	<u> </u>	
State Registrar	31. Date filed Maril Day Year)	Registr	ar's Signature	1	0			• • •	

ORIGINAL

OCME

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB 19 2010

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008096

29d. Date signed (Month, Day, Year)

35 PULFORD AVE, BELAIR, MODELL

and manner stated

in Novalaine po

/32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) INDREW NOWAKENST-1 MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day MARY PHILLIPS MUSE 2010 <u>January</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7204 Oakley Rd. Glenn Dale Prince Georges 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1 □ M 2 € F 66 263-60-1998 June 16, 1943 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 24 No MD Prince Georges Glenn Dale 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7204 Oakley Rd. 20769 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 No 1 ☐ Yes 2 No 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Director GW University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jack Phillips Alberta Stewart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Clifford Muse Jr. - Husband</u> 7204 Oakley Rd. Glenn Dale, Md. 20769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillside Cemetery 1-30-2010 Panama City, FL 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Malignant Neoplasm Uterus Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year

Physician /Medical Examiner

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Important: If ite
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Physician

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Baltimore, Maryland 21215-0036

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P.O. Box 68760,

Division of Vital Records,

Hospital or Attending Physician:

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						24a. Was an autopsy performed? 1 □ Yes 2 ₩ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
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27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 □ Yes		3d. Describe how injury	occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory)	ory, office	28	Bf. Location (Street and City or Town, State)	Number or Rural Route Number,
29a. Certifier 1	Certifying Ph	ysician: To the best of my kno niner: On the basis of examina	owledge, death occurre ation and/or investigati	ed at the time, da	te and place, ar	nd due to the cause(s)	and manner as stated. place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)



State Registrar

(Month, Day, Yea 2 8 2010

29b. Signature and title of certifi

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 4:30 PM Barbara Ellen McDonald Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington County Hagerstown Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6 Sex Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Min. Director 214-34**-1**960 77 Apri] Usual Residence of Decedent 28a-f show 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13031 Pennsylvania Ave. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 9 1 Never Married 2 Married Maryland 21215-0036 should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Personal Residence injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Barclay Kasecamp Rosa Farris Kasecamp permit. Page 1 and 2 should the Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary McDonald-son 218 Amherst Lane Falling Waters, WV 25419 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park 1-30-2010 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home Signature of Funeral Service License 1331 Eastern Blvd. North Hagerstown, ay 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician disease or condition Medical resulting in death) Due to (or as a conservence of): [']Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical metastatic IE EEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed? Yes 2 No this certificate 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director; to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 L ending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 044996

State

Registrar

DHMH 17 Rev 7/2009

spans Rd Boonstoro MB 21713

30. Name and address of person who completed sause of death (Item 23a) (Type, Print)

32. Registrar's Signature

for Malle

31. Date filed (Month, Day, Year)

JAN 29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Marylan		artment of He rtificate of D				
	8		Registrar 1. Decedent's Name (First, Middle, Last)		inicate of D	Calli	2. Date of Dea		3. Time of Death
н	Physici		Wilbur Gordon Nock				Month January	y 28, 2010	09:23 A ^M
4	/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death	0 00110001	4c. County of Dea	
•			29987 Polks Road		Princess	Anne		Somerse	et
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h 9. Bi y, Year) C	rthplace (State or Foreign country)
	Director		214-36-/224 / /1	Yrs.			08-09-		yland
	and t		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Mary -fsho ieda	to	MD Somerset P	rinces	a Anno				1 □Yes 2 No
	r 28a notif	Director	10e. Street and Number	Tinces	10f. Zip Code			10g. Citizen of What C	ountry?
	th with		29987 Polks Road		21853	3		USA	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U	J.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No-	- 14. Race - Am Black, Wh	
36	or its		1 ☐ Never Married 2 Married 1 ☐ Yes 2 No	- 1	\.	Specify:		Specify:	
Ö	hours tural" al Exa	d by	3 Wildowed 4 Divorced Year or Dates:	16a Decer	dent's Usual Occupat	tion		16b. Kind of Busines	White
7	n 72 i "nat ledica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	kind of work done du DO NOT use retired)	iring most of work	ring	TOD. KING OF DUSINESS	o/madaty
7	with jiene.	E	Elementary/Secondary (0-12) College (1-4or 5+) 12 none		ercial Fig	_		Seafood	
ק	other other	BeC	17. Father's Name (First, Middle, Last)				e (First, Middle,	Maiden Surname)	
/lar	should be f and Mental I s marked oi umatic eve	TO E	Everett E. Nock			Anne Ma	son		
Maryland 21215-0036	2 should be filed v and Menta! Hygie Is marked other t aumatic event, th		19a. Informant's Name/Relationship (Type. Print)					er, City or Town, State,	' '
	ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Mary Emily Nock/wife				ncess Ar	nne, Md 218	
Baltimore,	Pages 1 nent of P int: If ite		1 Abunal 2 Ucremation 3 Hemoval from State	-	sition (Name of matory or other place	i i		20c. Location - City o	
Ē	it. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (Specify) S 21. Ugnature of Funeral Aprice Lipensee		ill Memory		5/2010	Hebron, Ma	ryland
Ba	permit. Pag Department Important: I any Injury o				2. Name and Address inman Fune				
	4		M002 36a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	th. Do not ent	er the mode of dying	rset Ave , such as cardiac	or respiratory a	cess Anne,	Approximate
	Physician		/ / "	sont		mom			Interval Between Onset and Death
$\hat{\mathcal{J}}$	/Medical	(ofisease or condition resulting in death) a. Due to (or as a consecution)		60 (C(C	WOTTE			
	Examiner		Constitution and disconnection						
Н	p Æ	iner	Sequentially list conditions, if any, leading to himmsulate cause. Enter Underlying Cause (Disease or injury	querice of):					
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consection of the consection	augnos ofic					
60,	ficate be executed physician and sthe burial-transit		Due to (of as a consecu	quence oi).					
68760	physics the	edical	d						
Box (leath certif attending I for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregn					23d. Date of d	elivery
m.	death e atte	icia	in the past 12 months?		□Ectopic pregnancy □ Other <i>(specify)</i>			Month	Day Year
P.O.	The law requires that the death certi ate has been signed by the attending age 2 should be detached for use a	Physician/M	9 ☐ Unknown						
S, F	es tha gned se del	ру Р	Part II. Other significant conditions contributing to death but not res	sulting in the u	nderlying cause giver	n in Part I.		obacco use contribute	
ord	w requir been si should b						10	Yes 2 No 3 I	Probably 4 ☐Unknown
ec	has be ge 2 sh	Completed					24a. Was autor	osy prior to	autopsy findings available completion of cause of
E	: The cate ha	ပ္ပ					perfo 1□ Yes	ormed2 death?	s 2 No
Vital Records,	hysician: Th nis certificate I director, paç	Be	25. Was case referred to medical examiner? Hospital: Hospital:		Othor	26. Place of Deat			
0	Phys	- T	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ 27. Manne of Death 28a. Date of Injury	ER/Outpatier 28b. Time o	IL OLIDON	4 LI Nursing He		dence 6 Other (Sp	ecify)
on	iding Ph th. After this funeral	tion	1 ■Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury	Work'	? es 2 □ No			
Division or	or Attending Physician: ufter death. Director: After this certifics in by the funeral director, p	ifica	3 Suicide 6 Could not be determined 28e. Place of injury - At h		reet, factory, office			Street and Number or I	Rural Route Number,
	tal or s afte al Dir	Certification:	4 Homicide building, etc. (Speci	119)			City or Tou	wn, state)	
	e Hospital or Attenome 24 hours after death E Funeral Director: etely filled in by the		29a. Certifier (Check only) 1 Certifying Physican: To the best of my knu 2 Medical Examiner: On the basis of examin.						
	To the Hospital o within 24 hours aft To the Funeral D completely filled in	Medical	one) and manner stated. 29b. Signature and title of contributions.		29c. License			29d. Date signed Mo.	
	Nii Nii		23b. Signatura and the discharge		Iku	27 7		7 7)
7	73		30. Name and address of person who completed cause of death (fler	m 22a\ /T.ms	Print)	10		4	
	10		Mitchell Gittleman, M.D., 3141			rkwy, Su	ite 103	, Salisbury	, MD 21804
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Sign.	ature		-			
	Regist	ar	FFR 0.4 2010 Persua	A J	make !				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 12:59 PM Betty В. Nob1e 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbur Loasta Wicomico HOSOH Lake Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 K Hours 07-12-1918 213-22-8911 Pennsylvania Director 91 Yrs. Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location death with the Maryland event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 I No Somerset Princess Anne 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 30474 Pine Knoll Drive 21853 USA 12. Was Decedent Ever in U.S. Armed Forces?,
1 ☐ Yes 2 ☑ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Beauty Salon none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Wesley Martin Gretta B. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1405 Allenwood Drive, Salisbury, MD 21801 Sue Cabell/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 02/02/2010 Salisbury, Maryland 22. Name and Address of Facility Hinman Funeral Home 21. Signature of Funeral Service Aigenses M00295 Somerset AVe Princess Anne, MD 21853 27 . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sech lin Interval Between nmediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ rate has been signed by the atterpage 2 should be detached for a in the past 12 months? Day Pregnant at time of death Yes 2 No 9 🗆 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No After this certificate 1 Yes 2 No after death.

Director: After this certific in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Descripting Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number rectionare To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and title of certifie 29c. License number 505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registra

GREGORIO

31. Date filed (Month, Day, Year)

soul-

5302 CHINABERRY DR. SALISBURY, MD 21801

M. BELLOSO, M.D.

32. Regi rar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

eith Edward Neal		tment of Health and Mental H ificate of Death	ygiene Reg. No. 2010 04739
Physician/ Medical Examine	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year January 20, 2010 3. Time of Death 1526 hrs
	Facility Name (if not institution, give street and number) Prince George's Hosptal Center	4b. City, Town, or Location of Death Cheverly	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last 213-06-0428 1X M 2 F 41	st birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Location	10d. Inside City Limits
*	DC W	ASHINGTON	1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once al Director	10e. Street and Number 1321 EASTERN AVENUE N.E.	10f. Zip Code 20019	10g. Citizen of What Country? USA
er death wi	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	13. Was Decedent of Hispanic Origin? (Sinf Yes, specify Cuban, Mexican, Puerto	
hours aft natural' Examine		16a. Decedent's Usual Occupation (Give kind of viduring most of working life, DO NOT use reti	work done 16b. Kind of Business/Industry red)
5-0036 led within 72 hour Hygiene. other than "natu	Elementary/Secondary (0-12) College (1-4 or 5+) 1 2 TH	TRUCK DRIVER	PRIVATE
다 트립션 프레	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)
2121 2121 ould be fil I Mental I marked ic event,	JULIUS E. NEAL 19a Informant's Name/Relationship (Type, Print)	BARBARA 19b. Mailing Address (Street and Number or F	WELLS Rural Route Number, City or Town, State, Zip Code)
MD nd 2 sh alth and in 27 is	BARBARA NEAL/MOTHER 20a. Method of Disposition	1027 HIGGINS WAY HYAT	TTSVILLE, MARYLAND 20782
5	1 Burial 2 Acremation 3 Removal from State Cre	ematory or other place)	Date 20c. Location - City or Town, State 29/2010 RIVERDALE, MARYLAND
Baltimo permit. Page Department o Important: injury or ott	4 Donation 5 Other Specify: RTV 21. Signature of Funeral Service Licensee	22 Name and Address of Facility	B. JENKINS FUNERAL HOME
	23a Part I. Enter the disease, or complications that caused the death. D	7474 LANDOVER ROAL	LANDOVER MARYLAND 20785
Physician Matical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound to the B Due to (or as a consequence of):		Between Onset and Death
5	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
ted Insit Examiner	cause. Erner Underlying Cause (Disease or injury that initiated		
executed an and al - transit	events resulting in death) Last Due to (or as a consequence of): d.		
be exe sician sician outial -	UNPENDED AMENDED		
ox 6876 ath certificat attending ph or use as the sician/M	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal death 3 Ectopic pregna	23d. Date of delivery ncy Month Day Year
O. B. at the de di by the trached f	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
S, P.O. puires that the signed by a detact be detact ld be detact ed by P.O.			1 Yes 2 V No 3 Probably 4 Unknown
Division of Vital Records, ral or Attending Physician: The law require ra after death. The Director: After this certificate has been siled in by the funeral director, page 2 should bertification: To Be Completed			24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Recysician: The his certificate director, page	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 El	26 Place of Death (Check of R/Outpatient 3 DOA Other Nursin	only one) g Home 5 Residence 6 Other:
of Viring Physical directions on: To	27. Manner of Death 28a. Date of Injury 2	8b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
IVISION or Attending after death. Director: / I in by the fi	2 Accident Investigation Jan 20, 2010	1 Yes 2 No	Subject shot
Division ospital or Attending tours after death. The neral Director: After filled in by the function: Certification:	3 Suicide 6 Could not be determined (Specify) Group Home	e, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 1312 Eastern Avenue N.E., Washington, DC
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in bedical Certific	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, and	
M S T S D	29b. Signature and title of certifier	29c, License number O.C.M.E.	29d. Date signed (Month, Day, Year) January 21, 2010
5	30. Name and address of person who completed cause of death (Item 23	3a)	
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	enn Street, Baltimore, MD 21201	
Registrar	JAN 2 8 2010 Sener B. San	le l	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legibl

		For		aryland / De						_	0171
	•	1 - State Registrar		C	ertifica	ate of L	Death		Rag. No	ZUIU	04/4
		1. Decedent's Name (First, Middle, Las	t)					2. Date of De.	ath Da	v Year	3. Time of Death
Physicia		De Thi Nguyen						Month 01	23		2140
/Medic Examin		4a. Facility Name (If not institution, give	street and number))	4b. Ci	ty, Town, or	Location of Death	0-		. County of Deat	
CAGIIIII	CI	Prince Georges C	ommunity i	Hoenital		Ches	erly		P	rince Ge	orges
Funeral		5. Social Security Number 6. S	9x 7. A	ge (In yrs. last birthd		der 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da	th		nplace (State or Fore
Director		212-23-3172	□M 2 ⊠ F	76 Yrs	Month	s Days	Hours Min.	10/14/			tnam
ס		Usual Residence of Decedent									
nylan how		10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Lim
Ma Ma	cto	MD Montgon	ery	Gaithe	rsbur	g					1.X Yes 2 □ i
72 hours after death with the Maryland natural', or Iteme 23e or 28e-f ehow disal Examinar roust se notified at	Director	10e. Street and Number	•		10f.	Zip Code			10g. Ci	tizen of What Co	untry?
17 wil		18097 Singing Pir	e Circle			2088	6		V	ietnam	
dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces'	Ever in U.S.	3. Was De	cedent of Hi	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No	-	14. Race - Ame Black, White	rican Indian,
after or its	显	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 21X☐ If Yes, Give	No		2 X No	Specity:	, thousand one,		Specify:	, 010.
ours Fig.	by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:		10103	263110	Specify.				tnamese
72 h	tec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. De	cedent's U	sual Occupa	ation during most of wor	kina	16b. F	(ind of Business/	Industry
within ene. then "	ם	Elementary/Secondary (0-12)	College (1-4or	5+) lif	DO NO	use retired	during most of world)				
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be file	Be	17. Father's Name (First, Middle, Last,					18. Mother's Nam	ne (First, Middle,	Maidei	n Sumame)	
should but marked	2	Cu Van Ngoyen					Gioi	Thi D	uon	g	
a. (C = = 1		19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Addre	ess (Street a	and Number or Ru	ral Route Numbe	er, City	or Town, State, 2	(ip Code)
ges 1 and 2 t of Health If item 27 i		De Ngo / Son		180	97 Si	nging	Pine Cir	cle Ga	ith	ersburg,	MD 20886
ten item		20a. Method of Disposition		20b. Place of Di cemetery,	sposition (/	vame of or other place	e)	Date	20c. L	ocation - City or	Town, State
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그 본론을 그		21. Signature of Funeral Service Licer		I C . LIII	22. Name	and Addres	ss of Facility Ft	Lincol	n F	uneral F	lome, Inc.
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		shock, or heart failure. List only Immediate Cause (Final									Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	u	ent Pnuems a consequence of):	onia						
Examiner			·		D.						
	5	Sequentially list conditions, if any leading to immediate		stitial Lu s a consequence of):	ng Di	sease					
ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
xecu end	Xar	that initiated events resulting in death) Last	Due to (or as	s a consequence of):							-
be e sician burit	Cal	L.									
phys the	음		d								
Physician: The law requires that the death certificate be executed this certificate has been signed by the attanding physician end ral director, page 2 should be detached for use as the burial-transit	Physician/Medio	IF FEMALE:	23c. If yes, outcome	e of pregnancy						23d. Date of de	iron.
attan for u	au	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	3 Ectopia	pregnancy			İ	Month	Day Year
the the	slc	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□ Unknown	it time or death	2 □ O(III⊕I	(specify)					
that the de ed by the detached	Ph	Part II. Other significant conditions of	ontributing to death	but not resulting in th	e underwin	a cause div	en in Part I	23e Did t	obacco	use contribute to	the cause of death
signed be det	à			but not tobuting in the	o unouny in	g caase giv	on arraci.				obably 4X Unkn
been si should	ted	Respiratory Fai						, ,			
hes by	Completed	Multiple Decubi	is					24a. Was	psy	24b. Were at prior to	itopsy findings avail: completion of cause
The ste h page	Į,							perfo	rmed?	death? o 1 ☐ Yes	2□ No
iician: Th certificete rector, pag	a)	25. Was case referred to medical					26. Place of Dea	th (Check only	one)	/	
ding Physician: The h. h. After this certificete h. funeral director, page	ToB	examiner? 1 □ Yes 2 🔯 No	Hospital: 1 ☐ Inpat	ient 2 🖾 ER/Outpa	tient 3	DOA Oth	er: 4 🗆 Nursing H	ome 5 Resi	dence	6 ☐Other (Spe	cify)
		27. Manner of Death	28a. Date of Inj	ury 28b. Tim ay Year) Inju		28c. Injur	y at	28d. Describe	how inju	ury occurred	
Attending r death. ector: After by the fune	Certification:	1 Natural 5 Pending 2 Accident investigatio		ay roar, inju	м		Yes 2 □No				
Attend r death. ector: /	=======================================	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of in	njury - At home, farm	street, fac	tory, office					ural Route Number,
afte Dir din	ert	4 Homicos	bullaing, e	etc. (Specify)				City or To	WII, SIAI	10)	
To the Hospital or Attentwithin 24 hours after death To the Funerel Director: completely filled in by the	Medical C		niner: On the basis	t of my knowledge, d							
To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner's			29c. Licens	e number		29d D	ate signed (Mont	h. Dav. Year)
S E E		255. Signature and title discontinion	111th	M		1)77	723	MA	1/	20-1	2000
					1	10	1101		1	xs/o	(L
2		30. Name and address of person who	completed cause of	death (Item 23a) (Ty	pe, Print)				•	6-	
		Revathy Murthy, N	D 6180 I	andover R	oad_C	hever	ly, MD 2	20785			
Sta		31. Date filed (Month, Day, Year)	92. Reg	trar's Signature							
Registr	22	CABANTIN /A		ALC: NO.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Amend#26.PerPhys.PGC2-1-10c@ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jänuary 25, 2010 7:00 A M Mabel Owens Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgamery If Under 1 Year If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2X I Alabama Hours Min February Director 331-24-7971 88 Usual Residence of Decedent show 10b. County filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f Maryland Montgomery Rockville 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 20853 U.S.A. 4211 Aspen Hill Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) Marriott College (1-4 or 5+) Supervisor Flite Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Viola Gayles Thomas Wooley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Goodwine (Daughter) 4211 Aspen Hill Rd. Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State Farmingdale, 4 Donation 5 Other (Specify) 201b Signatur of uneral Service Licenses Cemetery New York Rendon/Hale Funeral Home Mul 9013 Annapolis Rd. Lanham, MD 20706 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Dementia Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Pregnant at time of death Other (specify) Month Dav the Unknown ģ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? A Q Ovarian Cancer 1 Yes 2 X No 3 Probably 4 Unknown certificate has been sir irector, page 2 should ! Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

Yes 2 No 1 ☐ Yes 2 ☐ No After this certifical funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Hospice Casev House Other: 2 **X** No ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA X Norsing Home 5 Residence 6 X Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury ☐ Accident ☐ Suicide Investigation 6 Could not be | Director: / 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours af Funeral Dieted filled in Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) MD33755 01/28/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Bindu Joseph 6001 Muncaster Mill Rd. Rockville, MD 20855 Bindu Joseph

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 1 2010

32. Registra Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	1 - State Registrar	of Marylan		artment of H tificate of L			giene Reg. No.	0 04742	
			Decedent's Name (First, Middle, Last)					2. Date of De Month	ath	3. Time of Death	
	Physicia Medic		Ethel Elizabeth	1:00P M							
	Examin	er	4a. Facility Name (if not institution, give street and	4c. County of De							
	Francis	H	Carriage Hill Nursing 5. Social Security Number 6. Sex	10Me 7. Age (In yrs. Ia	et hirthday)	Bethesda If Under 1 Year	If Under 24 Hrs		Montgom		
	Funeral Director		043-07-6469 1 ^{□ M 2} 🖫	F 90	Yrs.	Months Days	Hours Min.	4/4/19	71 ⁷ 9" Co	Birthplace (State or Foreign Country) Onnecticut	
	d ow		Usual Residence of Decedent 10a. State 10b. County			- '					
	ıryland 1-f sh ied a	Director	Maryland Montgomery	Che	, Town or Loc					10d. Inside City Limits	
	or 28g	Dire	10e. Street and Number	Clie	vy Cn	ase 10f. Zip Code			10g. Citizen of What	1 ☐ Yes 2 ☐ No	
	with t	Funeral	4450 South Park Ave.			20815			USA	Sountry :	
	death items ier m		11. Marital Status 12. Was D	ecedent Ever in U.S Forces?_	5. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-	14. Race - An	nerican Indian,	
36	after	d by	1 Never Married 2 Married 1 7	es 2 XNo Give		☐ Yes 2 🗓 No		o riloan, oto.,	Black, Wh Specify: W		
8	nours natura ical E	Completed	Year of 15. Decedent's Education	Dates.	16a, Deced	ent's Usual Occup	ation		16b. Kind of Busines		
215	in 72 l e. nan "r Med	dmo	(Specify only highest grade comple Elementary/Seconday (0-12) College	eal) e (1-4 or 5+)	(Give k life. DC	ind of work done o NOT use retired)	during most of wo	rking	100. Killa of Basilles	s industry	
7	d with lygien ther th	Be C	12		Hospi	tality Se			Restauran	t	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	10 B	17. Father's Name (First, Middle, Last) Ferruccio Alviani				18. Mother's Na Maria		Maiden Surname) enerri		
ary	nould I nd Me s marl smati		19a. Informant's Name/Relationship (Type, Print)		19h Mailin	n Address (Street :			r, City or Town, State, I	Zin Code)	
ž	d2sh altha n27is ertra		Gail Kelly/Daughter			irra Dr.,				21p 3 0000)	
ore	of He Mitten		20a. Method of Disposition 1	20b. Pl	lace of Dispos	sition (Name of atory or other place	e)	Date	20c. Location - City	*	
Ē	t. Pag tment rtant: ijury o		4 Donation 5 Other (Specify)	Ar		atory or other place n Nat'l (3/2010	Arlington		
Ba	permi Depar Impo any ir	, J	21. Signatur 1 Funeral Service Licensee					_	Kalas Fund ill, MD. 20		
			23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause or	at caused the death each line.	. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory an	est,	Approximate Interval Between	
	Physician, Medical	Immediate Cause (Final disease or condition Dysphania									
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	cuted nd transit	Examiner	triat mitiated events	niddle cen		artery d	listribut	ion			
_	law requires that the death certificate be executed ras been signed by the attending physician and 2 2 should be detached for use as the burial-transit	alE	resulting in death) Last Due	to (or as a consequ	ence of):						
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89	certif ending use a	N/ue	Lob. Was decedent program	outcome of pregnar	ncy	Estania prognana			23d. Date of c	lelivery	
Box 68	death he attv	Physician/M	1 Ves 2 X No 4 P	regnant at time of dental records at time of t		Other (specify)			Month	Day Year	
o.	at the id by t detach		Part II. Other significant conditions contributing t	o death but not resu	ılting in the ur	nderlying cause giv	ren in Part I.	23e Did to	hacco use contribute	to the cause of death?	
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ord	w requ	plete						24a. Was a		utopsy findings available	
Vital Records, P.O.	The lar ate ha	Completed						autop perfo 1 🗆 Yes	med? death?	es 2 No	
<u> </u>	cian: ertifica	Be (25. Was case referred to medical examiner?				ace of Death (Che		ZCINO		
≥	Physic this o	မှ		☐ Inpatient 2 ☐ E	ER/Outpatient 28b. Time of		4 A Nursing F		ence 6 Other (Spe	ecify)	
Division of	ding th.	Certificate:		te of injury onth, Day, Year)	injury	28c. Injury work M 1 \square		28d. Describe h	ow injury occurred		
SIO	Atter er dea ector. by the	ərtifi	3 Suicide 6 Could not be 28e. Pla			treet and Number or F	ural Route Number,				
2	ital or urs aftural Dir ral Dir lled in		DC	ilding, etc. (Specify)				City or Tow	n, State)		
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. on the Funeral Director. After this certificate has been signed by the attending it completed filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the 3 Certifying Nurse Praction	basis of examination	and/or investi	gation, in my opinio	n, death occurred	at the time, date a	nd place, and due to the	e cause(s) and manner stated.	
	To the Comp	~	29b. Signature and title of certifier	10		29c. License	number		29d. Date signed (Mor		
			Hamile	フ		D3557	9		1/22/2010		
2	6		30. Name and address of person who completed c Susan J. Miller, M.D.				5 Rethes	da. MD	20814		
	Stat	е		. Registrar's signatu			J Decines	u, in.			
	Registra		JAN 2 & 2010 Chine	V A. A	- aver						

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Joseph Gordon Po	eplinski State 1- For State Registrar		ment of Health and Mental I Ficate of Death	lygiene Reg. No. 201	0 04743
Physiciar Medical Examin	1. Decedent's Name (First, Middle,La	,		2. Date of Death Month Day Year February 11, 2010	3. Time of Death 1729 hrs
Wedical Examin	Joseph G. Pepli 4a. Facility Name (if not institution, gi	nski ve street and number)	4b. City, Town, or Location of Dea		
	Howard County General I		Columbia	Howard	
Funeral Director	5. Social Security Number 6. S		birthday) If Under 1 Year If Under 24H Months Days Hours M) For	Birthplace (State or reign
Director	229-37-9454 12 Usual Residence of Decedent	∠M 2 F 27	Yrs.	Nov. 6, 1982	Country)Maryland
any	10a. State 10b. County	10c. City, To	wn or Location		10d. Inside City Limits
land f show	Maryland Frede	rick Monro	via		1 Yes 2 X No
Mary r 28a- ed at	Maryland Frede 10e. Street and Number		10f, Zip Code	10g. Citizen of What C	ountry?
ith the 23a o	12213 South Debka		21770	United St	
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Maryland state: If item 27 is marked other than "natural", or items 33a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	12213 South Debka 11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No	13. Was Decedent of Hispanic Origin? (\$\frac{1}{2}\$ If Yes, specify Cuban, Mexican, Puerl		nerican Indian, Black,
after d	3 Widowed 4 Divorce	1 X Yes 2 No If Yes, Give Year 2003-2005	1 Yes 2 No specify:	Specify:	White
hours	15. Decedent's Education (Specify of		 Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re 		ss/Industry
36 hin 72 e. than "	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last	College (1-4 or 5+)	Student	Colleg	· A
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical Tropic Comments.	17. Father's Name (First, Middle, Last			e (First, Middle, Maiden Surname)	
21215 Montal Be fill Mental H marked c event, I	Richard Edward Pe			Henderson	
D 2'should and Maris ma	9 19a. Informant's Name/Relationship (19b. Mailing Address (Street and Number or	•	
and 2 sho and 2 sho fealth and tem 27 is traumati	Richard E. Peplin 20a Method of Disposition	ski/ Father 20b. Plac	12213 South Debkay Co	Ourt, Monrovia, Mary Date 20c. Location - City	
nore ages 1 at of F	1 Burial 2 X Cremation 3		natory or other place)	/15/2212	
Baltimore, M permit. Pages I and 2 Department of Health Important: If iten 2 injury or other traun	4 Donation 5 Other Specify 21. Signature of Funeral Service Lice	see Stau	ffer Crematory Ind.2/ 22. Name and Address of Facility Stauffer Funeral I	15/2010] Frederic	k,Maryland_
	Jode DU	Jenus -	Stauffer Funeral 1621 Opossumtown	lomes P. A. Pike, Frederick,Ma	ryland 21702
Physician	23a. Part I. Enter the disease, or comfailure. List only one cause on e		not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disease a or condition resulting in death)	Infective endo Due to (or as a consequence of):	carditis		Death
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1876 rtificate ing phy as the	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnan 1 Live birth	cy 2 Fetal death 3 Ectopic pregr	23d. Date of deliv	ery Day Year
Box 68760, a death certificate be the attending physic ed for use as the bur	JUNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	4 Pregnant at time of death			
that the de ted by the detached f	Part II. Other significant conditions	9 Unknown	ting in the underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
P.C es that igned I be deta	Hodgkins Lymp	homa	, , ,	1 Yes 2 No 3 Pr	robably 4 🗸 Unknown
w requir					autopsy findings available o completion of cause of
eco he law nte has	<u></u>	<u> </u>		performed? death?	?
Vital Recysician: The list certificate director, page			26 Place of Death (Check		100 2 110
Physici r this c	1 Yes 2 No			ng Home 5 Residence 6 Oth	ner:
n of V		28a. Date of Injury (Month, Day,Year)	b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
Division of Vital Records, P.O. tal or attending Physician: The law requires that the safer death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director.	Pending 2 Accident Investigat	28e Place of Inuny - At home	, farm, street, factory, office building, etc.	28f. Location (Street and Number or I	Rural Route Number City
Division of spital or Attending hours after death. neral Director: After filled in by the fune	3 Suicide 6 Could not determine	De	,	or Town, State)	The state of the s
		· · · · · · · · · · · · · · · · · · ·	death occurred at the time, date and place, and investigation, in my opinion, death occurred		
To the Ho within 24 To the Fu complete	one) 2 Medical Examine 29b. Signature and title of certifier	and manner stated	29c. License number	at the time, date and place, and due to	
	(4/111	1154	O.C.M.E.	February 12, 20	

State Registrar

DHMH 17 Rev 1/2001 OCME 2006

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D.

31. Date filed (Month, Day Year)

Assistant Medical Examiner

32 Registrar's Signature

			Amend #32, pe	ase Type or er DVR g90 State o	Print in 0 2/19/ of Marylan					ure All and Me	Copie ntal Hy	s Are	e Leg	ible.	0.1	7!!
	_		State Registrar 1. Decedent's Name (First, Middl	e. Last)		Cei	tificate	of E	Death	2	Date of De	Reg. No	o. U	IU	U 4	f44
	Physicia Media		Darlene						Month	Da	ay 20	Year	3. Time o	AM		
	Examir		4a. Facility Name (if not institution		of Death				County of Death							
	Funeral	Washington C	ast birthday)	If Under 1		ersto If Under		Date of Bir	rth	Was		gton lace (State	or Foreign			
	Director		178-40-9202	6. Sex 1 □ M 2 🔀 F	6	-	Months	Days	Hours		(Month, Da	ay, Year 3, 1	946	Coun	PA	_
	and show	å	Usual Residence of Decedent 10a. State 10b. County	,	10c. Cit	y, Town or Lo	cation				-			1	0d. Inside (City Limits
	Maryla 28a-f	Funeral Director	PA Fra	nklin		Way	nesbo	oro	ı						1 ☐ Ye	s 2 X No
4	th the	al D	10e. Street and Number				10f. Zip C		60				g. Citizen of What Country?			
	ath wi ems 2 r mus	nue	12599 Mentz 11. Marital Status		doad edent Ever in U.S	S. 13. \		. 72		ain? (Specify	Yes or No-				an Indian	
36	after de Il", or it xamine	þ	1 Never Married 2 XMa 3 Widowed 4 Divorced	Armed Fo rried 1 Tes If Yes, Giv	rces? 2 🏝 No e	- 1	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:						14. Race - American Indian, Black, White, etc. Specify: White			
9-00	hours natura iical E	letec	15. Decede	ent's Education		16a. Deced	lent's Usual (Occupa	ation			16b. k	Kind of Bu			
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	(Specify only high Elementary/Seconday (0-12)	est grade completed) College (1		life. D	kind of work of O NOT use re .stere	tired)	-	_			dica		,	
	filed wall Hyging all Hyging distributions of the went, went,	Be	17. Father's Name (First, Middle, Last)								rst, Middle,					
Maryland	uld be Ment narked natic e	잍	Philip Baer						Ma	abel I	Langdon					
Mar	2 shouth and the and the strain traum		19a. Informant's Name/Relations Donald A. Pa				er or Rural Ro Gap F						17268			
	of Heal of Heal of item		20a. Method of Disposition	- Huspan	ICI I 20h E	Place of Dispo	eition (Mamo	of					ocation -			17200
imo			1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (State St	emetery, crem Pet ische	natory or othe er v s)	er place Cer	^{e)}	$\mathtt{Feb}^{\scriptscriptstyleDate}_{ullet}$		Sp:	ring	Gro	ove,	PA
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other		21. Signature of Funeral Such e	Licensee	~ .	22	. Name and	A d dres	s of Facilit	y J.J.	Hart w Fr	enst	ein	Mort	uary,	Inc.
	Medical Examiner	Examiner	23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter of Adapting Cause (Disease or iinjury)	a. Due to (ch line.	PERIT					spiratory ar	rrest,		/	Approxima Interval Be Onset and	tween
Box 68760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{PN} \) No 9 \(\text{Ulnknown} \)	d	come of pregna Birth 2 Feta	ncy	Ectopic pre		у				23d. Date		ery Day	Year
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U			30. Name and address of person	who completed caus	e of death /ltam	23a) (Tuno 17	riot)	15	81.)		Fe	6 8	, 2	.070	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 23a per phys. G907 9/7/10 dk
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 25 20T0 2:40 P M Rosina Frances Pantaleo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Hospice Dove House | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F 85 219-16-3768 Director Maryland July 19, 1924 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinations. 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shov edical Examiner must be notified at Director Westminster 1 ☐ Yes 2 No Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21158 205 St. Mark Way Apt. 230 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ∐Yes 212 No Specify: Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Personnel Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mamie Palmisano Joseph Provenza ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald G. Pantaleo, Sr./Husband 205 St. Mark Way Apt. 230, Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of Garantist) (Parties of Place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb. 4, 2010 Owings Mills, Maryland Veterans Cemetery 21. Signature of Funeral Service Licensee Prince Arthrefality Home and Chapel, P.A. Me-412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? Year 1 ☐ Yes 2 ☐ No 5 Other (specify) the 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed certificate 2 No Yes 2 1No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check o 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and pranner stated. 29b. Signatu and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WIT 5+5 Name and address of person who completed cause of death (Item 23a) (Type, Print) 12016 of strumted 1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 04746 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certific	ate of	Death			Re	g. No.			
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Funeral Director				In yrs. last bir	thday)	If Under 1 Year Months Day		24Hrs. 8 Min.	B. Date of Birth	1952	Y) 9. Birt Foreig Cou	hplace (State or n Washington untry) DC	
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yland a-f she t once	ţċ	10e. Street and Number	ester	DCI		10f 7in Code		<u> </u>	140	0.00			
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.	Director	616 Ocean				10f. Zip Code 218				10g. Citizen of What Country? United States			
ath wil	Funeral	11. Marital Status 1 Never Married 2 Marr	12. Was Decedent Evented Armed Forces?		13. Was If Yes	Decedent of Hi s, specify Cuba	spanic Origin n, Mexican, P	i? (Speci Puerto Ric	fy Yes or No- an, etc.)		e - Americ e, etc.	can Indian, Black,	
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21215-0036 unid be filed within 72 hours after Mental Hygiene, marked offter than "natural", ic event, the Medical Examiner	Be	Stephen A	. Puleo					Kat	herine	aiden Surname Simms	•		
nore, MD 2 ages 1 and 2 shoul nt of Health and M t: If item 27 is m other traumatic	To	19a. Informant's Name/Relationship Maelynn Terry			7 Ens	ign Dri	ive, Be			per, City or Tow 21811	n, State,	Zip Code)	
ore, sslan of Hea If iter		20a Method of Disposition 1 A Surial 2 Cremation	Removal from State		of Disposition	on (Name of ce r place)	metery,	D	ate	20c. Location -	- City or 1	Fown, State	
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite njury or other tr		4 Donation 5 Other Spec	fy:		rrect	ion Ce	emetery	y 2/5	/2010	Clinto	on, l	Maryland	
Baltimo permit. Page Department of Important:		21. Signature Funer Source Licensee MD1464 22. Name and Address of Facility Lee Funeral Home, Inc 6633 010 Alexandria Ferry Road, Clinton, Md 20735											
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/Medical Examiner	1	failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	each line. a. <mark>Contact Gunshot '</mark>	Wound of I								Between Dinset and Death	
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequ	ence of);	-								
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760, ficate be g physical sthe burn		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome			2				23d. Date of			
Box 68's death certiff he attending of for use as	Physician	past 12 months?	1 Live birth 4 Pregnant at tim	e of death 5		death 3 (S <i>pecify)</i>	Ectopic pr	regnancy		Month	Da	ay Year	
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of Vit ding Physic After this	음	1 Yes 2 No 27. Manner of Death	28a Date of Injugy		itpatient 3		ry at Work?			esidence 6 w		Scene	
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Divisipital or At ours after dours after defined birect filled in by	ertific	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. L						or Town, Sta			I Route Number, City		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical C		cian: To the best of my kr										
To To	Me	29b. Signature and title of certifier	and manner stated.			29c. License				29d Date signe			
		0 00	116	_		O.C.I	M.E.		1	January 30,		,	
00 ==	ŀ	30. Name and address of person who	completed cause of death	n (Item 23a)			_						
005			Chief Medical Exar	miner 11	1 Penn	Street, Balt	imore, ME	21201	I				
St Regist	ate	31. Date filed (Month, Day, Year) FEB U 2 201	32. Registrar's S		Ma Be	A. C.							
Regist	ren	· = 0 0 0 CO1	U Seneur	Feb. Staff	arka								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20/0 Keyshaun 0957 lah /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Cheverly George's Hospital rince If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State of Foreign Country) **Funeral** 1 M 2 □ F Months **Director** NONE Usual Residence of Decedent 10c. City, Town or Location 10a. State or 28a-f show 10d. Inside City Limits the Medical Evaniner must be notified at 1 ☑Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2506 items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 6 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 la lif Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☑ No Specify ò Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any Injury or other traumatic event, it a Magnes. Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Koosevel ပ ashadia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, *ip Code) 11/02 ampheli 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State Chever 14 2-10 Prince Georges Hosp 4□Donation 5 Nother (Specify) HOSP Disp 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Prince Georges Hospital Center 2001 Hospital Drive Cheverly, 1 Ma M 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is to be a light to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Dise to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. 1 □Yes 2 ┗HNo s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has b irector, page 2 sh 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 □No 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation r death. ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and time of certifie 29c. License number 29d. Date signed (Month, Day, Year) D26819 1-21-2010 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address , Cheverly, MD Hospital DR haudr Registrar's Signat State Registrar

			For State Registrar	State of Maryland		artment of H tificate of D			001	0 04748	
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\ \ -	Examir	er	The Johns Hopkins Hos 5. Social Security Number 6. Sex	· ·	ast hirthday)	Baltimore If Under 1 Year	City	. 8. Date of Birth	9. B	irthplace (State or Foreign	
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	r 28a-f shov	irector	MD 10b. County MD 10e. Street and Number	Toc. City		LTIMORE		1	0g. Citizen of What C	1 X Yes 2 □ No	
36	within 72 hours after death with the Maryland ene. than "hatural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral Director	910 NORTH STREEP 1 11. Marital Status 1 Never Married 2 Married 3 Nowidowed 4 Divorced	Z. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1	Vas Decedent of Hir f Yes, specify Cubar	P1224 spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	USA 14. Race - Am Black, Wh Specify:		
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Maryland 2		To Be C	17. Father's Name (First, Middle, Last) EUGENE F. COOK				BARBA	me (First, Middle,	ARRIS		
			19a. Informant's Name/Relationship (Type ANGELA BAILEY/SIS	STER	<u> </u>				r, City or Town, State, BURG, WV 2		
Baltimore,	Pa Int:		20a. Method of Disposition Burial 2 Cremation 3 Re	moval from State	emetery, cren HOPE C		2010	5,	20c. Location - City of MARTINSE	BURG, WV	
Bal	permit. Departin Importa any inju		21. Signature of Funeral Service Licensee Charles VW. Bla 23a. Part 1. Enter the disease, or complice	ations that caused the death			G ST., MAI	RTINSBURG,		30X 821,	
,	Physician /Medical		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ause on each line. Intra cere by Due to (or as a consequence)	al hem		g, 00011 as 001 al	0 01 100phatory a		Interval Between Onset and Death	
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			- 1 -11	mpleted cause of death (Iten	n 23a) (Type,	Print)	-000		January 3		
	Sta Regist		31. Date filed (Month, Day, Year) FEB 19 201	32. Registrar's Signat	ure		600	NOTH WO	ne ot, Daitin	nore, MD, 21287	

De

10-01045 Rhonda Ragano Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 04749

		1- For State Registrar				Ce	ertifica	ate of	Death	7				Reg. No	0.		
Physici edical Exami		1. Decedent's Name												3. Time of Death 0730 hrs			
		4a. Facility Name (i	b. City, Town, or Location of Death Waldorf					4	4c. County of Death Charles								
		2836 Ridge		2.0		7. Age (In yrs.	1 (1.1.4)						lo Dita of		M/DD/YYYY	In nie	paleon /Ctota or
Funeral Director		5. Social Security N 216-92-0		6. Sex		Months	Days	If Under Hours	Min.	May			Foreigi Cou	Washington Official Property of the Control of the			
*		Usual Residence of	f Decedent						L								
, any			10b. County			10c. City		or Locatio									10d. Inside City Limits
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16 n 72 hc an "na ical Ex	ompleted	Elementary/Seco	ondary (0-12)		College (1-	4 or 5+)	R.	luring mos	st of work	ling lite. L	OO NOT U	ise retire	d)				
215-0036 be filed within 7: tral Hygiene. ked other than ent, the Medical	duic	12			4		Λ,	N .		1.0		T	=			Me	dical
15-C filed v Il Hygi ed oth	ပ	17. Father's Name	(First, Middle, e Edwai	,	irn	Cr.				18					n Surname)		
D 21215-003 should be filed within and Mental Hygiene. 7 is marked other the natic event, the Med	o Be	19a. Informant's Na				DI .	19b	. Mailing	Address	(Street a			Redma		City or Towr	ı, State,	Zip Code)
MD 2 nd 2 shou alth and N m 27 is n	T	George 1	Nairn ((Broth	her)		8	750]	Locu	st Gi	rove	Driv	ve, Po	ort '	Tobaco	.0.	MD 20677
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygeiene. In the Health and Mental Hygeiene and matural, or items 23a or 28a-fishe mit. If item 27 is marked other than "natural", or items 23a or 28a-fishe or other traumatic event, the Medical Examiner must be notified at once	1	20a. Method of Disp 1 Burial 2		2 D	amayal fra		Place o	f Dispositi	on (Nam	e of ceme	etery,		Date	20c	. Location -	City or	Town, State
Pages hent of ant: I		4 Donation 5	122		emovariio	in State		Cre	nato:	ry Fe	eb 9,	201	10		Clint	on.	Maryland
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		21. Sign ture of Fu	neral Service	Licensee	1	Mo/5	33	22. Na	me and A	Address o	f Facility	lee I	Tunera	al H	Ome,Ir on, MI	1066	33 014
Physician	Ċ	23a. Part I. Enter th	e disease, or	complicatio	ons that ca	used the deat	h. Do no	PILCA	MUIIU.	тта т	CII)	/ NUc	1U, UI	コエロしり	on, m	, 20	Approximate Interval
/Medical Examiner		failure. List on Immediate Cause (on eath lin a.	10	Cirrho	sis	of 1:	iver								Between Onset and Death
Examiner		or condition resulting		Due to		consequence											
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8760, ifficate be	n/Me	IF FEMALE: 23b. Was decedent	pregnant in th	230	c. If yes, o	utcome of pre-	gnancy							2	3d. Date of	,	Veer
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Box 68 e death certi the attendin ed for use as	Physicia	1 Yes 2 N	No 9 🗸 Unk	nown 9	Unknov	vn			, (+,	·//							
Division of Vital Records, P.O. Box 68 the Hospital or Attending Physician: The law requires that the death certifind 24 hours after death. The Funeral Director: After this certificate has been signed by the attendin apletely filled in by the funeral director, page 2 should be detached for use a	by P	Part II. Other signi	ficant conditi	o ns contr	ributing to	death but not	resulting	in the un	derlying	cause giv	en in Par	t I.				_	he cause of death? ably 4 Unknown
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of Vital Records, ing Physician: The law requir After this certificate has been sumeral director, page 2 should I	: To	27 Manner of Deat		2	8a Date o	f Injury Day,Year)	28b. T	ime of Inj	ury 2	Bc. Injury	at Work?	2	8d Describ	pe how in	njury occurre	ed	
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To the best of my more of Death 250 Manner										r or Rur	al Route Number, City						
Hospital 24 hours Funeral																	
To the Hos within 24 h To the Fur completely	Medical	(Check only	Medical Exar	niner:On th		examination	_										
To Wit	Me	29b. Signature and	title of certifie		manner ste	ited.			29c.	License r	number			29d	l. Date signe	d (Mon	th, Day, Year)
		Violes	inte Dr	nell	hell					O.C.M	.E.			Fe	bruary 7,	2010	
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Si Regis	tate	31. Date filed Mon	197	110	VI MELLA	A A	als.	and of	13								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Robinson Terri Lee AM 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15112 Old Oldtown Road Oldtown Allegany Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Y Oct 26, **Funeral** 1961 1 □ M 2 □ ¥ Months Days Hours Min. 214-80-8261 Director 48 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f shorevent, Ire Medical Examinar mart be regified at MD Allegany Oldtown Director 1 □Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15112 Old Oldtown Road 21555 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No Specify þ Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hyglen. Important: If item 27 is marked other that any injury or other traumatic event, If a NORE. homemaker own house 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence William Bendle Doris Lee (Crosten) Bendle 2 19a. Informant's Name/Relationship (Type. Print)
Bruce Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21555 husband 15112 Old Oldtown Road Oldtown 20b. Place of Disposition (Name of cemetery, crematory or other place)
Vale Summit Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 2/12/2010 MD Frostburg 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility all Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** l 4 FAR disease or condition resulting in death) /Medical Due to (or as a prequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner DUG to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) P.O. hed by the a 9 Unknown 9 Unknown is certificate has been signed director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 🗌 Yes 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐Yes 2 ☐No Be 25. Was case referre medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ER/Outpatient 3 DOA this in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation hours after death. Accident 1 ☐ Yes 2 ☐ No Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours a filled Medical 29a. Certifier 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

DHMH 17 Rev 1/2001

the within ?

State

29b. Signature and title?

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Registrar

29c. License number

BISHOP WALSH DRIVE CLIMBERLAND, MD ZISOZ

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 1800 KATHLEEN HENRIETTA RODGERS Tanuary 23, 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL MONTGOMERY Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕏 F Director 578-28-3303 92 3/25/1917 Wilson, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County show ?7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examinar must be notified at Director 1 XYes 2 No DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 601 Edgewood Street NE #321 20017 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: ģ 3 ₩ Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Cook DC Public Schools permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If item 27 is marked other 1 any injury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Eli Barnes Maggie Alston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2700 Texas Ave. SE #5 Washington, DC 20020 Donna Roberts-Sparks / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/28/2010 Metropolitan Alexandria, VA 21. Signature of Funeral Service L 22. Name and Address of Facility Alexander S. Pope Funeral Home MD1085 23a. Part r Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2617 Pennsylvania Ave. SE Washington, DC 20020 Approximate Interval Between Onset and Death nmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): failure Examiner Chronic Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed and burial-tra Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Vear Pregnant at time of death 5 Other (specify) detached 9 ☐ Unknown signed by t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been siç , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 No 2 -NO 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | □ 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this ို 28a. Date of Injury (Month, Day, Year) 27. Manner eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Hatural 5 Pending death. n 24 hours after death. e Funeral Director: A letely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 2

Baltimore, Maryland 21215-0036

Box 68760,

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Division of Vital Records,

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAHMINA SILVD SULL, SINAS SPORT 32. Registrar's Signature

Registrar

Medical

29a. Certifier

(Check only one)

1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1)00 60 100

29d. Date signed (Month, Day, Year)

AUMED

CF3

Registrar

Bowie

Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14300 Gallant

31. Date filed (Month, Day, Year

JAN 2 8 2010

-28-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Day Month 4:45 a M 30 2010 Iva Mae RANNELLS Jan Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington <u>Williamsport Retirement Village</u> <u>Williamsport</u> 8. Date of Birth (Month, Day, Yea March 8 1 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 1 □ M 2 🕅 F Hours Min 88 Director 1921 213-12-7429 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2X No Maryland Washington Hagerstown 10f. Zip Code 10e, Street and Numbe 10g. Citizen of What Country? Funeral 1008 Oueen Anne's Court 21740 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 💢 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: "natural", 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Para professional State Government other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be Harry Edward Smith Charlotte Elizabeth Harper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. David Perkins - Nephew 18725 Briarwood Drive, Hagerstown, Md. 21742 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 2/2/2010 Hagerstown, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Minnich Funeral Home halul (A Wilson Blvd., Hagerstown, MD. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months?

1 Yes 2 No Month Year Day the detached g Unknown P.O. e Hospital or Attending Physician: The law requires that the 124 hours after death.

• Funeral Director: After this certificate has been signed by leted filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi

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State Registrar

NOR egistrar's Signatur FEB02

rson who completed cause of death (Item 23a) (Type, Print)

3

29b. Signature and title of certific

30. Name and address of p

only one)

ITAGERSTOWN, MD 21742

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

2333

29d. Date signed (Month, Day, Year) 1 10

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Americate of Maryland De Garlinen of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Carroll Dean Swisher Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany nedical Cent Jumperlano 6. Sex 1 **X**M 2 ☐ F . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** June 8, 1954 55 Director 234-84-7151 Usual Residence of Decedent . Page 1 and 2 should be filed within 72 hours after death with the marynanument of Health and Mental Hygiene. It has the firm 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director W Hampshire 1 X Yes 2 No Ramev 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 459 N. Bolton St. 26757 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George G. Swisher Martha Fowler Hutchings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karren Swisher (wife) 459 N. Bolton St. Ramey, W 26757 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State Scarpelli F.H. PA 1/27/10 4 ☐ Donation 5 ☐ Other (Specify) Cresaptown, MD 21. Signature of Funeral Service License 22. Name and Address of Facility McKee Funeral Hone 115 E. Birch Lane Romey, W 26757 23a. Part 1. Enjer the disease, or complications that diused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Esque Itally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Certificate: To 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be Accident Suicide
Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Praction to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check D0066604 dress of person who completed cause of death (Item 23a) (Type, Print) 2500 Willowbrook &d, Cumberland, MD 21502 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2010 Kathleen Margaret Sneddon 2:35А. м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 3118 Gracefield Road, #T20 Silver Spring If Under 1 Year | If Under 24 Hrs Social Security Numbe 7. Age (In vrs. last birthdav 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 031-80-8634 1 □ M 2 🔯 F 90 Yrs Months Hours Nov. 12 England Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20904 3118 Gracefield Road, T-20 England Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Force Black, White, etc. 1 \square Never Married 2 \square Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Malcolm Cambray Smith Lillian Hales 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5300 Westport Road Chevy Chase, Maryland 20815 Fiona C. Carson -daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) metropolitan Crematory 2/3/2010 Alexandria, Virginia 21. Signature of Funeral Service Licensee ²Donald Wesporg Wardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Chronic Obstructive Pulmonary Disease disease or condition resulting in death) vear Medical Due to (or as a consequence of): Examiner Ecosontielly fist conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and de detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant a 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation 2 ANO 1 Tes 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 XNo 24a, Was an autopsy performed? Yes 2 X No this certificate has ral director, page 2 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 XResidence 6 \square Other (Specify) Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural injury work?
1 Yes 2 No 5 Pending Investigation Accident filled in by the 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) February 3, 2010 roller D36716 20

State Registrar 31. Date filed (M. Pay, Year)

Andrew Kundrat, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04756 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February 2010 12 21 A M SUMMERS WANDA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital Frederick Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 M 2 D F Days 62 West Virginia Yrs. **Director** 214-46-5391 March Usual Residence of Decedent ms 23a or 28a-f show 10b. County and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene.
Health and Mental Hyglene.
To is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21701 200 East 16th Street United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: White 3 ☐ Widowed 4 🔯 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 10 Insurance Company Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry William Locke Edna Barney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Gray / Son 11920 Main St. Apt. 105-A, Libertytown, MD 21762 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town State

Division of Vital Records, P.O. Box 68760

permit. Page 1 Department of Important: If is any injury or conce.	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	(y)	cemetery crematory or other Rest haven Memorial Gard	ens Feb.	5, 2010 Fre	derick,	Maryland						
Depart Import any inj	21. Signature of Funeral Service Licens	see	22. Name and Resthav 9501 Ca	Address of Facility en Funeral toctin Mtn.	Services, Hwy. Fred	Skkot Co lerick, M	dy 21701						
hysician/ Medical Examiner	23a. Part 1. Enter the disease, or come shock, or year failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	ath. Do not enter the mode of ARY EMB (quence of):		or respiratory arrest,		Approximate Interval Between Onset and Death						
after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit. Certificate: To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last												
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certificate has been signed by the attending physiciar lirector, page 2 should be detached for use as the buring be been buring by Be Completed by Physician/Medical	Part II. Other significant conditions of COPD DIABLE LUNG CANC	tes mere 1		24b. Were au	Probably 4 Unknown autopsy findings available to completion of cause of								
nis certific I director, To Be (25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	☐ ER/Outpatient 3 ☐ DOA	1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one)									
fter ti	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)		Injury at work? 1 Yes 2 No	28d. Describe how in								
s after des l Director d in by th	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, factory, c	ffice	28f. Location (Street City or Town, Sta		ral Route Number,						
within 24 hours after death. To the Funeral Director: A completed filled in by the funeral Medical Certifics	(Check 2 Medical Exam	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
To th	29b. Signature and title of certifier	m ms		cense number		Date signed (Montl							
6	30. Name and address of person who A • DONELSOA 31. Date filed (Month, Day, Year)	completed cause of death (Ite	em 23a) (Type, Print)	JO ANSON	DR, FA	LOERIC	K 21702						
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature A. Apark	and a			· · · · · · · · · · · · · · · · · · ·						
1 17 Rev 7/2009			Ø.		7								

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TITEM#12perFH,G900,2/24/2010 WS Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 04757 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Samue 1 R. Steel, Jr. January 28, 20108:30 p. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8921 Yellow Springs Road Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 130M 2 - F Months Hours Min. 214-28-0855 Feb 14 Day, Year 31 78 Maryland **Director** Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a, State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Funeral Director Maryland Frederick Frederick 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21702 8921 Yellow Springs Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 X Yes 2 1948-1952 If Yes, Give 1948-1952 þ 1 Never Married 2 Married Black, White, etc. and 2 should be filed within 72 hours after af Hygiene.

d other than "natural", c Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 DWidowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) event, the 8 Electrician U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mentai I marked o ပ Samuel R. Steel, Sr. Edna C. Pope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Health tem 27 8921 Yellow Springs Road Frederick, Maryland 21702 Maurine Steel / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot February 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) **Brook Hill Cemetery** 2, 2010 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of X-1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the dises ase or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Approximate Interval Between Onset and Death MYO CARDIAL Immediate Cause (Final INFANCTION Physician/ disease or condition Medical resulting in death) [']Examiner ANTERY DISENTE ATHERUSC LETLOTIC Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or linjury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month 5 Other (specify) 9 Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral Certificate: 27. Manner of Deal 28b. Time of 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accide injury 5 Pending Accident Investigation 2 🗆 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2-01-2010 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) House- AUE FREDERICK. A KAZMI, MO 814 10+1VA 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

Barks

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
PI line a-b, 23e, 28b, 28d, per ME g901 3/19/10 TT
State of Maryland / Department of Health and Mental Hygiene

		1- State Amended#1perMD	State of Ma	ryland 7 2/1/10	Depa <i>Cer</i>	irtment of H	lealth D <i>eath</i>	and Me		giene Reg. No		04130	
Physic	ian	Decedent's Name (First, Middle, Last)	Geraldine	Dorne	y Sa				2. Date of De.	ath Day	v Year	3. Time of Death	
/Medi Exami	cal	4a. Facility Name (If not institution, give st	treet and number)	Nursina	T	4b. City, Town, or	Location		Janua	4c.	27, 2011 County of Dea	th	
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Funeral Director		5. Social Security Number 6. Sex 1□	M 2,⊠ F 7. Age	(In yrs. last bi	rthday) Yrs.	Months Days	Hours	Min.	8. Date of Bird (Month, Da April	и 26 1	923 Ma	thplace (State or Foreign ountry) Issachusetts	
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with the 3a or 28a at be noti	Funeral Director	10e. Street and Number 4206 Sugar Pine Co	ourt			10f. Zip Code	208	366		-	tizen of What C Inited S		
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72 hours "natural"	Completed b	3 ☑ Widowed 4 □ Divorced 15. Decedent's Educ (Specify only highest grade	168	Deced	lent's Usual Occup kind of work done o	ation during mo	ost of workin	g	16b. K	(ind of Business	s/Industry		
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and 2 should be should be saith and h.m. 27 is manner trauman		19a. Informant's Name/Relationship (Type Anne Salemme / Date		19		og Address (Street O. Box 5						Zip Code) tts 02205	
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10		29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name an a dress of person who co Grace Brooke Huffma 31. Date filed (Month, Day, Year) FEB 0 1	mpleted cause of de	8100 Sla) (Type,	School R	oad	Sano	ly Spri	ng,	Maryl	and 20860	
S Regis	tate trar	FEB 0 1	20 10 \ 2	rs Signature	A.	parke	,						

DHMH 17 Rev 1/2001

Smith

1. Decedent's Name (First, Middle, Last)

Charles Anthony

4a. Facility Name (If not institution, give street and number)

Physician

/Medical

Examiner

04759

9. Birthplace (State or Foreign

3. Time of Death

3:00 P M

Reg. No.

February 6, 2010

4c. County of Death

Allegany

2. Date of Death

4b. City, Town, or Location of Death

1.00			23217 McMullen	Highway			Rawl	ings		
	Funeral Director		5. Social Security Number 6. S 235–54–8216		i (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours M	Hrs. 8. Date (Mo	e of Birth Inth, Day, Ye Y 3 1
	pu. w		Usual Residence of Decedent 10a. State 10b. County		10a Ciby	Town or Loc	ation			
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980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Mardical Examiner must be notified at once.	Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2√√ Married 3 ☐ Widowed 4 ☐ Divorced	lispanic Origin an, Mexican, P Specify:	? (Specify Ye: uerto Rican, e	s or No-				
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Baltimore, Maryland 21215-0036	Pages 1 and of He and: If item ant: If item ary or other		20a. Method of Disposition 15 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif.		cer	netery, cřen	sition (Name of natory or other place em. Garde		02/09/ 2010	Ke <u>r</u>
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/ita	clan; ertific	Be (25. Was case referred to medical examiner?						Death (Check	
£	hysi this o		1y∑ Yes 2 □ No	Hospital: 1 ☐ Inpatie			t 3 □ DOA Oth	4 LI Nursir	ng Home 5	-
ion	ath. nr: After i	ation:	27. Manner of Death 1XX Natural 5 ☐ Pending 2 ☐ Accident investigation			28b. Time of Injury	28c. Inju Wor M 1 \square	ryat k? Yes 2 ∐ No	28d. De	scribe how
Divis	tal or Ath	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju building, etc	ry - At hom . (Specify)	ne, farm, stre	eet, factory, office		28f. Loc City	ation (Stree or Town, S
	he Hospi in 24 hour he Funer. pletely fill	Medical (nysician: To the best on iner: On the basis of and manner sta	examination					
	Vithi To ti	Ž	29b. Signature and title of certifier	() _			29c. Licens			29d.
			1 Carl	prew			D09	157		J.
		,	30. Name and address of person who					on and	1 a w -7 .	m 21
		0	Dr. Paul Snow, I	JPTY Med.]	±х.,	124 W	3rd St,	cumper.	land, N	1D 21

934 Pennsylvania 10d. Inside City Limits 1 ☐ Yes 2X No . Citizen of What Country? nited States 14. Race - American Indian, Specify: white b. Kind of Business/Industry Paper Manufacturer iden Surname) City or Town, State, Zip Code) gs, Maryland 21557 c. Location - City or Town, State yser, West Virginia al Home Maryland 21562 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No No ce 6 Other (Specify) injury occurred et and Number or Rural Route Number, State) se(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year) AN 8, 2010 21502

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

-8 2010»

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Maryland / [rtment of H tificate of L		Mental Hygie Reg	ne No.2010	04760		
	Physicia /Modic		1. Decedent's Name (First, Middle, La	*	fildred Schrar	nm			2. Date of Death Month Febru	Day 04, 2010	3. Time of Death		
1	/Medio Examin		4a. Facility Name (If not institution, given		ber) Rehab Center		4b. City, Town, or		aconing	4c. County of Dea	th Allegany		
	Funeral Director		Social Security Number 6. 8	- Table	. Age (In yrs. last bii		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		9 Rir	thplace (State or Foreign ountry) Maryland		
	il Z i 3-UU30 within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show	Director	Usual Residence of Decedent	Megany	10c. City, Tow	n or Loca	ation	Lonaconir		. Citizen of What Co	10d. Inside City Limits 1 18 Yes 2 □ No		
	23a or			ackson Stre				21539		USA			
920	urs after dea al", or items	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 ∐Yes 2 If Yes, Give Year or Dat	No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒ No Specify:			pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify:			
21215-0036	I within 72 ho giene. r than "natur Ine Medical I	Completed	15. Decedent's E (Specify only highest gr.			(Give k	ent's Usual Occup ind of work done o O NOT use retired	luring most of wor		b. Kind of Business	/Industry		
nd 2	led Lygi her nt, 1	Be Co	17. Father's Name (First, Middle, Last		2		-		ne (First, Middle, Ma	iden Surname)			
ıryla	d 2 should be fi th and Mental F ?7 is marked ot traumatic ever	ပ္	19a. Informant's Name/Relationship	John Bra		o. Mailing	Address (Street	and Number or Ri	Ly Iral Route Number, C	dia Martin ity or Town, State,	Zip Code)		
, Ma			Betty Fazent		e		4 Ale		et, Lonaconing	g, Maryland,	21539		
Baltimore, Maryland			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	fy)	camata	ory, crema Oal	ition (Name of atory or other plac K Hill Cemete	ry	February 09 2010		ing, Maryland		
Baj	permit. Page Department Important: I any injury o once.		21. Signature of Funeral Service Lice	Lom		22.	Name and Addres	ss of Facility East Main St		n-McKenzie coning, MD 2	Funeral Home P./ 1539		
	cate be executed // Medical Examiner the prival-transit the burial-transit	ical Examiner		dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (o	or as a consequence	of):	CUMP	Acc	いりたか		Approximate Interval Between Onset and Death
.O. Box 68	the death certifi y the attending ched for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 tho 9 □ Unknown	1 Live bi	ome of pregnancy rth 2□Fetal death ant at time of death wn		Ectopic pregnancy Other (specify)	/		23d. Date of de Month	elivery Day Year		
rds, P.	iires that signed b	by	Part II. Other significant conditions	contributing to dea	ath but not resulting i	in the und	derlying cause give	en in Part I.	23e. Did toba		o the cause of death?		
		Completed							24a. Was an autopsy performe 1 □ Yes 2 D	prior to death?	utopsy findings available completion of cause of s 2 No		
Vital	Physician: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑No	Hospital:	patient 2 ☐ ER/O	utnationt	3 DOA Othe	ar:	ath <i>(Check only one)</i> Home 5 Residen	og 6 □Other /Sa	aciful		
	ing After uner	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date o (Month	f Injury 28b.	Time of Injury	28c. Injur Work		28d. Describe how		вопу)		
Division	tal or Attend rs after death al Director: ,	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	et, factory, office	28f. Location (Street and Ni City or Town, State)			umber or Rural Route Number,					
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	Medical			sis of examination a		estigation, in my o	pinion, death occ	e, and due to the cau urred at the time, dat	e and place, and du	e to the cause(s)		
	Voit Con	Σ	29b. Signature and title of certifier	Hyle	m		29c. Licens	6907		EBRUITE	104, ZOIU		
	Sta Registr		30. Name and address of person who Harit-Sidney MC 31. Date-Alled (Month, Day, Year) FEB - 5 20	925 BIS				erlord m	ayland		7		

State of Maryland / Department of Health and Mental Hygiene 2 [] | [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2010 0734 Nelda Helen Strong A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital Cecil E1kton 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Days Hours Min. (Month, Day, Year) ine 15, 1936 Director 214-34-3379 June Pennsylvania Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔯 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 56 Johnstown Lane 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes. Give Completed 3

Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than Electrical Motor Elementary/Seconday (0-12) College (1-4 or 5+) 10 Machinist Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Franklin Smith Anna M. Rentz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Cindy L. Smith/Daughter Box 1481, Elkton, MD P.O. 21922 20b. Place of Disposition (Name of Cherry Hill Methodist Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a Department of I Important: If ite any injury or ot February 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 16, 2010 Cherry Hill, MD 22. Name and Address of Facility
Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Failure Physician disease or condition resulting in death) Congestive Medical Due to (or as consequence of) Examiner Sequentially list conditions, it my leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Day Pregnant at time of death 1 Yes 2 2 No the 9 Unknown P.O. ģ signed to Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed -un1 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown s been signal 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has lirector, page 2 s autopsy performed? Yes 2 2 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 NER/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 🗌 Yes 2 🗌 No - death Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 65902 2/12/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carlo E. Gopez, Cathedral 3 31. Date filed (Month, State 32. Registrar's Signature Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CHARLES SWEENEY DAVID JR. FEB 2010 10:15A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CLINTON GEORGE'S PR. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 [Director 28-54-3432 1943 WASH AN. 10 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified MD CHARLES WHITE PLAINS 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10209 FORD TERRACE 20695 U. S. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1X X/es 2 No If Yes, Give Year or Dates. 60 – 62 Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" 3 Widowed 4 Divorced WHITE permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygene. Important: If item 27 is marked other than "naturaly injury or other traumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) & LAB. TECHNICIAN PINEFIELD MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES DAVID SWEENEY SR. ALICE FURBUSH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLA L. SWEENEY/WIFE 10209 FORD TERRACE WHITE PLAINS, MD 20695 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Donation 5 Hother (Specify) 2-10-2010 METRO. CREMATORY ALEXANDRIA, VA 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 Signature of Funeral Service Licenses M00641 5635 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Non 28 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year sate has been signed by the page 2 should be detached g 🗌 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Xes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performe this certificate 2 No 1 Yes ☐ Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner's 2 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Tes 1 Inpatient 2 K ER/Outpatient 3 I DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending 2 🔲 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) To the Hospital on within 24 hours aff Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated under 0001923 02/08/11) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10HMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No LU Certificate of Death Day 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** DORIS MAE SWINDALL 2:33 AM 2010 Hebruary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CHAPLES 101+A MEDICal ivista IN FER 9. Birthplace (State or Foreign WASH • , D • C • 5. Social Security Number If Under . Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2√ F 578-20-4390 89 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Examiner must be notified at MD. CHARLES LA PLATA 1X Yes 2 □No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō death with 1 MAGNOLIA DRIVE 20646 U.S.A. 23a Funeral items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2√∑ No Specify 2 Specify: WHITE 3 √Widowed 4 ☐ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) uth and Mental Hygiene.

27 Is marked other than traumatic event, the Man Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CLAUDE FRANKLIN GICKER BEULAH ELIZABETH FLOWERS ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Is r DELORES A.SMITH-DAUGHTER P.O.BOX 100 COBB ISLAND, MD. 20625 permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr. once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State METROPOLITAN CREMATORY 2-10-2010 ALEXANDRIA, VA. 4 □ Donation 5 □ Other (Specify) 2. Name and Address of Facility 21. Signature of Juneral Service Licensee M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one vause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final An **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner マング Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (6r of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a be detached f 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 2 No 1 Tes 3 Probably 4 Unknown certificate has been sirector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **X** No 1 ☐ Yes 2 ☐ No 1 □Yes ours after death.

eral Director: After this certificatile in by the funeral director, illed in by the funeral director, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 3 NO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∏ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier within 24 hor To the Fune completely fi and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar JEORGE

U V

person who completed cause of death (Item 23a) (Type, Print)

then 11345 PembrookE

D-20629

QUARE SUITE 103 Waldorf MD 20603

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Year Month Ellen L. Shelton 2010 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince Georges ${\tt Clinton}$ 6. Sex 1 ☐ M 2 🔀 F 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number **Funeral** Min. Days Hours 76 Yrs. Director 238-46-8439 Sept.13 NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** must be notified 28a-f 1 X Yes 2 ☐ No MD Forestville 10e. Street and Numbe 6 10g. Citizen of What Country? 23a 7420 Marlboro Pike 20747 ted States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural". 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Caretaker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o ည 27 is marked traumatic e Chester Whitfield Beatrice Eason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lane 22485 <u>1</u>1791 Fullers George, Health tem 27 Dona Wiggins/daughter or other item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1/25/10 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Heritage</u> Memorial <u>Cemeterv</u> Waldorf.Md 22. Name and Address of Facility Hodges & 21. Signature of Funeral Service Licenses Edwards F.H. 3910 Silver Hill Rd. Suitland.Md Approximate Ay Interval Between Onset and Death 23a. Par 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick or heart failure. List only one cause an each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner dans Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit 0 Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No g Unknown 9 Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying gause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy or Attending Physician: The On 1 \(\sum \) Yes 25. Was case referred to medical examiner? Division of Vital funeral director, 26. Place of Death (Check only one) Hospital Other: မှ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending Vatural 24 hours after death. Funeral Director: Af 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Hospital Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature a UMNER 22,2010 5 address of person who completed cause of death (Item 23a) (Type, Print) UMNE

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 24, 2010 3:00A OLIVIA STEVENSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SUBURBAN HOSPITAL MONTGOMERY BETHESDA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 □ M 2 😾 F Months Days NEWYORK 79 Director 578-44-2889 05-16-1930 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No WASHINGTON DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1019 17th PLACE NE #3 U.S.A. 20002 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give 1 X Never Married 2 ☐ Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) MACHINE OPERATOR GOVERNMENT 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental + is marked o permit. Page 1 and 2 should be 1. Department of Health and Mental Important; If item 27 is more any injury or other. 2 MARY STEVENSON UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1019 17th PLACE NE #3 WASHINGTON, DC 20002 THERESA A MILES/DAUGHTER 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 1-27-2010 RIVERDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME Signature of Funeral Service Licenses 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li retai down 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year n signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? After this certificate 1 ☐ Yes 2 No 1 Yes 2 No Vital the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) ot 27. Manger of Death 28b. Time of 28c. Injury at e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th 28d. Describe how injury occurred Natural Accider injury work? 1 ☐ Yes 2 ☐ No 5 Pending Division Accident Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier 1/Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) re and title of certifier 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Research BLVD Smite 330 MENDHIRAT 2401 31. Date filed (Month, Day, Year) State JAN 2 9 2010 Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Standridge, Sr. 2315AM C. Henry 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Doctors Community Hospital Lanham Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X**□M2□F Months Days Hours Myg. Dec. 1925 North Carolina Director 84 266-26-6337 Usual Residence of Decedent 10a. State 10b, County 10c. City, Town or Location 10d, Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at within 72 hours after death with the Maryland Director 1 Yes 2X No Hyattsville Maryland Prince Georges 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20784 U.S.A. 6916 Parkwood St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces?

12 Yes 2 NowWII Black, White, etc. þ 1 Never Married 2 XMarried Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Madra (Give kind of work done during most of working life. DO NOT use retired) A.H. Smith Liquid Elementary/Seconday (0-12) College (1-4 or 5+) Construction 12 Asphalt Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Willie Forrest Earl Standridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6916 Parkwood St. Hyattsville, MD 20784 Peggie Standridge (Wife) Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place)

Chesapeake Crematory 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 1/29/10 Beltsville, Maryland 4 Donation 5 Other (Specify) Funeral Service Licens 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, / enock, or heart failure. List only one cause on each line. Approximate Interval Between ardiae Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner 10 my Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence or Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 L 9 Unknown 2 🗌 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Cardiac 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an oranar this certificate has autopsy page 2 performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending after death. 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0032761 Jaket 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lanham MD. 2070 6 9470-Annapolis Rd. #418 Jaleh Daee MO 31. Date filed (Month, Day, Year) State

Registrar

JAN 2 9 2010

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Physician/ , Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and

Physician/

Medical

Examiner

Funeral

Director

23a or 28a-f shov

Completed by Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any hiury or other traumatic event, the Medical Ex≅miner must be notified at any hiury or other traumatic event, the Medical Ex≅miner must be notified at another.

Baltimore, Maryland 21215-0036

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After this certificate has been signed by the attending physician

Division of Vital Records, P.O. Box 68760

m	17. Father's Name (First, Middle, Last)				18. M	other's Name (F	First, Middle, Maid	den Surname)	
ည	Arthur Smith				Eı	nma Mul	len .		
	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailing Address ((Street and Nur	nber or Rural R	loute Number, Cit	y or Town, State, Z	ip Code)
	Shirlene Butler	- Daughter		4203 Bisho	pmill 1	Dr. Up	per Marl	boro, MD	. 20772
W 3	20a. Method of Disposition		20b. Pl	ace of Disposition (Name emetery, crematory or oth	e of	Dat	te 20	c. Location - City o	r Town, State
	1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci.			yland Veter		2-5-20	010 c	heltenhar	n. MD.
	21. Signature of Funeral Service Licens		, -	<u> </u>		cility		Maryland	
	Victorina	CWood	4	<u> 4308 S</u>	<u>uitlan</u>	d Rd.	Suitland	Maryland 1, MD. 20	746
	23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused the one cause on each line.	ne death	. Do not enter the mode	of dying, such	as cardiac or re	espiratory arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	Cong	.057	tive He	art t	Failus	5		Onset and Death
	resulting in death)	Due to (or as	onseque	ence of):					
<u>_</u>	Sequentially list conditions,	b. Vie. 5	26.4	Es type	11				
ine	if any, leading to infinediate cause. Enter Underlying	Due to (or as a c	orisaque	since oi).					
хап	Cause (Disease or iinjury that initiated events	· (0/0)	renz	ACTECY		ye 4.5.	<u> </u>		
al E	resulting in death) Last	Due to (or as a c	onseque	ence of):					
dic		l d							
Me.	IF FEMALE:	230 If you outcome of	prognan	101					
ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2	Fetal	death 3 - Ectopic pr				23d. Date of de Month	Day Year
ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at til 9 ☐ Unknown	me or a	eath 5 Other (spe	эсіту)			Month	Day Tour
P.	Part II. Other significant conditions of	ontributing to death but	not resu	Iting in the underlying ca	ause given in P	art 1.	23e. Did tobac	co use contribute t	o the cause of death?
d b							1 ☐ Yes	2 □ No 3 □ F	Probably 4 🛛 Unknown
ete									
mpl							24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
ပိ								No 1 ☐ Ye	s 2 🗆 No
Be	25. Was case referred to medical examiner?	Hospital:			Othor	eath (Check or	nly one)		
٦,	1 Yes 2 No 27. Manner of Death	1 Inpatient 28a. Date of injury	-	R/Outpatient 3 DOA 28b. Time of	A 4 L			e_6 Other (Spe	cify)
ate	1 Natural 5 ☐ Pending	(Month, Day, Y	'ear)	injury M	c. Injury at work?		d. Describe how in	njury occurred	
Ę	2 Accident Investigation 3 Suicide 6 Could not b		- At hor	ne, farm, street, factory,	1 Yes 2	_	f Location Ctrass	t and Number or Ru	und Davida Mumbar
Medical Certificate: To Be Completed by Physician/Medical Examiner	4 Homicide determined	building, etc. (\$	Specify)	ne, fami, street, factory, c	onice	201	City or Town, Si		urai noute Number,
ical	29a. Certifier 12 Certifying Phys	l sician: To the best of my	knowle	dge, death occured at th	he time, date a	nd place, and d	lue to the cause(s	s) and manner as st	ated.
Ned	(Check 2 L Medical Exami	iner: On the basis of exam se Practioner: To the bes	nination	and/or investigation, in my	y opinion, death	n occurred at the	e time, date and pl	lace, and due to the	cause(s) and manner stated.
<	29b. Signature and title of certifier	60		29c. l	License numbe	er	29d.	Date signed (Mont	h, Day, Year)
	to hin to	wills.		\mathcal{D}	0050	339	,	1/27/	10
	30. Name and address of person who d	completed cause of deat	h (Item _i	23a) (Type, Print)			\ _ \ I	1	N1 -
	John Wills 14	310 old M	acll	poro Pilhe	· Upr	1 1 DC	arlba	DIMO	40772
е	31. Date filed (Month, Day, Year)	32. Registrar's	Signatu	ire					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SAVOY ICLAIN В. :27 P M JANUARY 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Age (In vrs. last birthday) **Funeral** (Month, Day, Yea

MAY_16 1 Days Hours Min. 1 M 2 X 82 Director WASHINGTON, DC 1927 <u> 212-56-0591</u> 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27: is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD PRINCE GEORGE'S UPPER MARLBORO 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5310 ROBLEE DRIVE 20772 USA 11 Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: BLACK Specify: 3√ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC ENGINEER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CLARENCE PROCTOR HAZEL QUEEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4514 FRANK WARREN DRIVE HEPHZIBIH, GEORGIA YONNETTE TOOMER/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, 2/1/2010 LANDOVER, MARYLAND HARMONY CEMETERY ature of Juneral Service Licenses J.B. JENKINS FUNERAL HOME 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for 5 Other (specify) should be detached 9 Illnknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy performed page 2 2**X** No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 10 Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 🗔 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and person who completed cause of death (Item 23a) (Type

DHMH 17 Rev 7/2009

State Registrar JAN 2 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mary Janet Sawyer 2:15 Рм 2010 January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2752 Lorring Drive, #101 Forestville Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🖾 F Months Days Hours (Month, D 198-20-3823 83 Lorain, Director 1926 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2752 Lorring Drive, #101 20747 USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🛛 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 X Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Federal Government and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Andrews, Air Force Base 12 Supervisor other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Ment. Important: If item 27 is marked any injury or other trainmants one. ٩ John Dowdell Mary Sharp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Mary Montalvo / Daughter 3107 Voyage Drive, Stafford, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 1/27/2010 Alexandria, Virginia 4 Donation 5 Dother (Specify) Metropolitan Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Athoroselero disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year Unknown 9 Unknown Division of Vital Records, P.O. signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 tonknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Hospita Other: 2 🗌 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 Antural 5 Pending 2 Accident
3 Suist after death. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 001

State Registrar 31. Date filed (Month, Day, Year)

10-00865 Emily Stone Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mily Stone		1- For State	ate of Maryl		artment of			Menta	al Hy		Reg. No	20	10	0477
Physicia	an/	Registrar 1. Decedent's Name (First, Midd	le,Last)						12	2. Date of De	ath			3. Time of Death
edical Exami	ner	Emily May STON	IE							Month January	30, 20	Year 10		1227 hrs
		4a. Facility Name (if not institution	on, give street and n	umber)	4	b. City, To		ocation of	Death			c. County of		
\$ _b ,		Rt 40 and Mt. Aetna F		T ** * * * * * * * * * * * * * * * * *	1	Hagers		W. 1	0.441	lo p		Washing		
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under Months	Days	If Under	Min.	1			Foreign	nplace (State or
Director		215-37-8911	1 M 2 X F	17	Yrs.				L	Oct.	8 19	992	Cou	ntry) Maryland
any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Location	on							П	10d. Inside City Limits
	_	Maryland Wash	ington	Н	lagerstov	√ n								1 X Yes 2 No
ne Maryland or 28a-f show fied at once.	cto	10e. Street and Number				10f. Zip C	ode				10g. Ci	tizen of Wha	at Coun	try?
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	1522 Dual High	wav			2	1740	1				USA		
ath with the items 23a	ral	11. Marital Status	12. Was De	cedent Ever in U		Decedent	of Hispa	anic Origin		cify Yes or N	10-	14. Race -		an Indian, Black,
death or iter must	Funeral	1 X Never Married 2 M	arried Armed F	2 X No	If Ye	s, specify	Cuban, I	Mexican, F	'uerto H	tican, etc.)		White,		That is a
after	by F		orced If Yes, Give Ye or Dates:			Yes 2		specify:				Specify:		Thite
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	pe	15. Decedent's Education (Spe Elementary/Secondary (0-12)		1-4 or 5+)	16a. Decedent' during mo						16b.	Kind of Bus	iness/In	idustry
36 nin 72 s. than '	ple			1-4 01 5+)								***	1 0	
d with	Completed	10 17. Father's Name (First, Middle,	0		I Sti	ıdent	18	Mother's	Name (First, Middle	, Maider	H1g n Surname)	h S	chool
215 oe file ttal Hi ked o	Be (Sean Stone					מ	ebora	ah (Clay D	unna	want		
Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene, If then 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	To	19a Informant's Name/Relations	hip (Type, Print)		19b. Mailing	Address	(Street a	and Numb	er or Ru	ral Route N	umber, (City or Town	, State,	Zip Code) 21740
MD id 2 st lith an m 27 i		Deborah Dunnav	ant - Mot								. 1.	Hage	rst	own, MD.
ore, s l an of Hea If ite		20a. Method of Disposition 1 X Burial 2 Cremation	n 3 Removal f		Place of Disposit crematory or other		of ceme	etery,		Date	20c.	Location - (City or I	own, State
Page ment g		4 Donation 5 Other S	pecify:	Gr	eenlawn					2010				rt, MD.
Salt ermit. beparti mport	Ш	21. Signature of Funeral Service	Licensee			me and A				nich				
	41	23a. Part I. Enter the disease, or	complications that	caused the death										21740 Approximate Interval
Physician /Medical		failure. List only one cause	on each line.		i. Do not ontor the	o mode or	ayınıg, se	2011 03 001	al a 0 01 1	copilatory a	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	iodit, or riodi		Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		juries a consequence d	of):								-	
		Sequentially list conditions,	b											
	Examiner	if any, leading to immediate cause. Enter Underlying Cause		a consequence of	of):									
	Kam	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence o	of):								-	
be executed ician and initial - transit	a E		d											
be exo	dical	UNPENDED	AMENDED											
6876C certificate nding phys	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes,	outcome of preg		al death	3	Ectopic p	reanan	CV	23	3d. Date of c Month		ay Year
x 68 h certi tendin use as	cial	past 12 months?	4 Preg	nant at time of de	noth -	er (Specif	_	_Lotopic p	regnam	.,		Wienian		
Box e death c the atten ed for us	Physician/Me	1 Yes 2 No 9 V Uni	9 01111			- 11.								
cords, P.O. Box 68760, law requires that the death certificate be execut has been signed by the attending physician and should be detached for use as the burial - training burial - training burial - training burial - training - training burial - training - trainin	by P	Part II. Other significant condit	ions contributing t	o death but not r	resulting in the ur	iderlying c	ause giv	en in Part	I.		_	✓ No 3	_	he cause of death?
S, Fquires en signald be										24a. Wa				opsy findings available
aw rea) De							_		auto	opsy formed?	pr		empletion of cause of
Rec The l	Completed									1 🗸 Yes			✓ Yes	2 No
Division of Vital Records, also ratending Physician: The law requires after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	æ	25. Was case referred to medica examiner?	Hospital:	Inpatient 2	ER/Outpatient			f Death (C		-	Doniel	ence 6	Other	Sanna
of V Phys rer this	٦	1 Yes 2 No 27. Manner of Death	28a. Date	e of Injury	28b. Time of In			at Work?		8d. Describe			,	Scerie
anding th.	Certification:	1 Natural 5 Pend	(Mont	h Day Year) 2010	1222 hrs		1 Ye	s 2 🗸 N	lp	edestrian				
r Atte ter des irecto	fica		stigation 28e. Place	ce of Injury - At h	nome, farm, street	, factory, c	ffice bui	lding, etc.	2			and Number	or Rur	al Route Number, City
Div ours af	er		and a district of	Major Roa	d / Highway				R	or Town, t 40 and M	State) It. Aetn	a Rd, Hage	erstow	n, MD
Hosp 24 ho Func etely f			hysician: To the be											
Division of N To the Hospital or Attending Ph. within 24 hours after death. To the Funeral Director. After th completely filled in by the funeral	Medical	one) 2 Medical Exa	and manner	of examination a stated.	and/or investigatio				irred at	tne time, dat				
	Σ	29b. Signature and title of certific	er				License i						•	th, Day, Year)
		Tapula Jour	hall, ML)			O.C.M				Jai	nuary 31,	2010	
, , , , , , , , , , , , , , , , , , ,		30. Name and address of person Pamela E. Southall, M	•	ise of death (Iten Medical Exa		Penn S	Street	Baltimo	re. MI	D 21201				
)H-0	ate			egistrar's Signat	ure									
Regist		31. Date filed (Month, Day Year)	2 2010	2.	6 4.	41								

DHMH 17 Rev 1/2001 OCME 2006 1, Decedent's Name (First, Middle, Last)

2010 Year **Physician** January 28, 9:45 P M Donald Lester Snyder /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10823 Roessner Avenue Hagerstown Washington 8. Date of Birth (Month, Day, Year) Sep 7, 192 Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1**X** M 2 □ F 209-12-9499 Yrs. 84 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is New Stoll Exs. when the rediffed at 10d. Inside City Limits 10b. County 10c. City, Town or Location **X**√Yes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10g, Citizen of What Country? 10823 Roessner Avenue 21740 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 | Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2**X**□No Specify: Specify: White 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daniel Hubert Snyder ပ Helen Laura McSherry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Helen L. Kline / Daughter 301 Radcliff Avenue Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Greenlawn Cemetery 02/01/2010 | Williamsport, Maryland 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 21. Signature of Funeral Service Licens 7606 Old National Pike Boonsboro, MD 21713 23a. In T. Enter the dislase, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Yav **Physician** KINSMY /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2□No 1 ☐ Yes 2 - No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 29a. Certifie 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Docs 7285 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N Walnu. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FFB 0 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

3. Time of Death

16b. Kind of Business/Industry trucking companies

14. Race - American Indian,

Black, White, etc.

Specify: white

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1X Yes 2 No

Big Pool, MD

6:12р м

17. Father's Name (First, Middle, Last) Bruce Nevin Snyder

Elementary/Secondary (0-12)

8th grade

Be

ဥ

Examine

Physician/Medical

Medical Certification: To

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19902 Sheridan Ave. Hagerstown, MD 21742

19a. Informant's Name/Relationship (Type. Print) Dora Jean Lewis daughter 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 3 Parkbead Cemetery 2010

20c. Location - City or Town, State Big Pool, MD

Reg. No. Z

4c. County of Death

10g. Citizen of What Country?

U.S.A.

Washington

2. Date of Death

8. Date of Birth (Month, Day, Year) 1 - 4 - 1922

Month Day 1-28-2010

Signature of Funeral Service Licensee

4 Donation 5 Other (Specify)

22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc 23 Part 1. Enter in disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or hear failure. List only one cause of each line.

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Irene Blake

Immediate Caus Final disease or condition resulting in death)

Due to (or as a consequence of):

Due to (or as a consequence of)

Due to (or as a consequence of):

College (1-4or 5+)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy 5 ☐ Other (specify)

teno Schestic andis Vanca

driver

23d. Date of delivery Month Day

Year

Interval Between Onset and Death

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

9 Unknown

Lastra illula

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Loner Suis Bunch

24a. Was an autopsy performed

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Be Completed by 25. Was case referred to medical examiner? 1 Yes 2 ₩o 27. Manner of Death

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 ANatural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide

6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

(Check only

29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

MA 01740

- NOUT

29b. Signature and title of certifier

D0018019

01/29/2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

340 MILL ST. HAGERSTOWN VASANT DATTA

31. Date filed (Month. Dav. Year) 32. Registrar's Signature FEB 01

State Registrar

OH-16H

within 24

Baltimore, Maryland

P.O. Box 68760.

Division of Vital Records,

Physician

/Medical

Examiner

9 Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
Purperal Director: After this certificate has been signed by the attending physician and letely filled in by the furneral director, page 2 should be detached for use as the burial-transit eneity filled in by the furneral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

23e. Did tobacco use contribute to the cause of death?

1 □ Yes 2 🖵 🛚 16 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Pother (Specify) 115555 Divinion

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Gwendolyn Virginia Schame1 2010 Medical anuary 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Williamsport Nursing Home Washington Williamsport 8. Date of Birth (Month, Day, Yea May 20, 1 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Min. Maryland Director 214-09-7579 90 1919 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No Maryland Washington Williamsport ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral U.S.A. 154 N. Artizan St. 21795 Was Decede. Armed Forces? Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates "natural", Specify: 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the 1 ang. 8 Receptionist Laundry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Reno Μ. Biddinger Virginia Otto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13644 Pauls Road Clear Spring, Maryland 21722 Linda Trumpower/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Haven Cemetery 2/1/2010 Hagerstown Maryland 21. Signature of Funer I Service License 22. Name and Address of Facility Rest Haven Funeral Chapel 21742 Pennsylvania Ave. Hagerstown, Maryland 1601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician 74 disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequ The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No Yes been signed by the be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 2 should Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page death? 1 Yes 2 No Yes or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 Tyes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year,

05H-1

State Registrar Shahid

31. Date filed (Month, Day, Year)

580 Norther

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahmood

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **Physician** Audrey C. Spear 12:00 P M January 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖫 F 220-20-0587 80 Director June 26, 1929 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Welfonl Evander is ust be rectified at Director 1 ☐ Yes 2 ☑ No Maryland Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9802 Millwick Dr. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 No Specify: 2 Specify: White 3

Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Retail Sales Hecht Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Culp Ethel Boardman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Spear/Son 204 Pond View Dr., Westminster, MD 21157 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lakeview Memorial Park 01/28/2010 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Pritts Funeral home and Chapel, P.A. Signature of Funeral Service Licensee 412 Washington Rd., Westminster, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed and burjal-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d, Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Dav Year 5 ☐ Other (specify) the a 1 Ves 2 No 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performed 1 □Yes 1 ☐ Yes 2 No 2 No funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day, Year) 27. Manne Theath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director; the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar DHMH 17 Rev 1/2001

State

WIL

29b. Signature ar

30. Name and ad

31. Date filed (Month, Day,

tle of certifier

Year

of death (Item 23a) (Type, Print)

32. Redistrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2010^a February 2:45 **Physician** Robert Lindberg Small /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Charles **Examiner** LaPlata Charles County Nursing & Rehab 8. Date of Birth (Month, Day, Ye Nov. 24, Birthplace (State or Foreign Country) if Under 1 Year | If Under 24 Hrs. Year) 1927 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 M 2 □ F Days **Funeral** Maryland 220-16-4623 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State 28a-f show 1 ☐ Yes 2 X No the Medical Examiner must be notified at LaPlata Charles Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a or U.S.A. 20646 6060 Rose Hill Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after death 1 XNever Married 2 ☐ Married 1 □Yes 2 🔀 No Specify: Specify: Black ь 21215-0036 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) U.S. Government permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Many Injury or other traumatic events. Elementary/Secondary (0-12) College (1-4or 5+) Power Explosives Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be Rosalie Ella Marshall James Chester Small 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6060 Rose Hill Rd., LaPlata, Md. 20646 Daughter Lisa V. Hercules 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 5 St. Josephs Catholic Church 20c. Location - City or Town, State Baltimore, 20a. Method of Disposition Pomfret, Maryland 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Williams Funeral Home, P.A. 21. Signature of Funeral Service Lice 4270 Hawthorne Rd., Indian Head, Md. M00668 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or her failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Due to (or as a onsequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23d. Date of delivery yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ģ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No 2 🖃 No 1 □Yes 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 ➡ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient ၉ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification:

ам

Year

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760 funeral director, within 24 hours after death

To the Funeral Director;
completely filled in by the

5 Pending investigation

6 ☐ Could not be

determined

1 Natural

2 Accident

3 Suicide

29a. Certifier

ical

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ce tifie who completed cause of death (Item 23a) (Type, Print) OLD LINK CANTER, PACE BBUL10 12070 32. Fegistrar's Signature State MICH Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY MARGARET TENNANT E. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner EASTON TALBOT HOSPICE HOUSE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M 2 X F Months Days Hours Min. 7/25/1923 Director 86 <u>215-14-3817</u> Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location must be notified at Director TALBOT NEWCOMB MD 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 23a 25886 WALNUT STREET 21653 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? 1 Yes 2 No ö þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 XWidowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) 12 a HOMEMAKER Be 17. Father's Name (First, Middle, Last) and Mental Fishers is marked o ျ þ MILTON E. EASON traumatic and 2 should 19a. Informant's Name/Relationship (Type, Print) item 27 i DENISE M. TAYLOR/DAUGHTER other t Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth Date 1 👿 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 2/5/2010 4 Donation 5 Other (Specify) SPRING HILL CEMETERY 21. Signature of Funeral Service Licenses NHON MERCE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events physician and sthe burial-trans resulting in death) Last Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 month 1 Yes 2 g Unknown sate has been signed by the page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 24a. Was an . 150TCS certificate 25. Was case referred to medical Division of Vital funeral director. Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After t 1 Natural 5 Pending work? 1 Yes 2 No s after death. Accident Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated completed To the I within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) NETTIE V. WILLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25890 WALNUT STREET, NEWCOMB, MD 20c. Location - City or Town, State EASTON, MARYLAND 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. SOUTH HARRISON STREET, EASTON, Approximate Interval Betwee Onset and Death MYK 14FA 23d. Date of delivery Year Month Dav 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) Z 10 completed cause of death (Item 23a) (Type, Print) 503 CYNWOOD DRIVE, EASTON, MD 21601 **ORIGINAL**

2010

14. Race - American Indian.

Black, White, etc.

4c. County of Death

TALBOT

USA

10:20 P

g. Birthplace (State or Foreign

10d. Inside City Limits

1 X Yes 2 No

MARYLAND

WHITE

State Registrar

RS 3

30. Name and address of person who

LUDWIG

31. Date filed (Mon

ÆGLSEDER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 3:00^A Dav **Physician** Month February 07, 2010 Thelma Marie Ternent /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Westernport Moran Manor Health Care Center If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 Maryland 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 X F Director 216-05-5856 July 03, 1916 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director Westernport Allegany Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with 1 Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or ? 25701 Shady Lane SW 21562 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify þ If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Silk Textile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace Neat Walter Kallmyer ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra 3373 Margaret Avenue, Stow, Ohio, 44224 Hugh Ternent- Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 08 1 ☐ Burial 2/XICremation 3 ☐ Removal from State Cumberland, Maryland **Cumberland Crematory** 2010 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home 13nandi Wilhelm Lonaconing, MD 21539 P.A. 8 East Main Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CORUNAN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 nknown Completed peem 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has l autopsy performed' certificate 212 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Surring Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ TNo 2 ER/Outpatient 3 DOA ဥ 1 ☐ Inpatient After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Year) 1 Natural 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 □ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

To the Hospital or Attending Physician: within 24 hours arter com.

To the Funeral Director: Aft

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day

(Check only one)

29b. Signature and title of certifier

UIT 32. Registra

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

1) 21244

29d. Date signed (Month, Day, Year)

	1 - State of Maryla		artment of I rtificate of		lental H	0	010	0477
	Decedent's Name (First, Middle, Last)				2. Date of D	Trog. Tro.	010	3. Time of Death
ian cal	Fonda K Tesoriero				Month 2	Day 3	Year 2010	2:45PM
ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Death			ty of Death	
м	Cakland Nursing & Rehab. Center		Oakla				-rett	
ı	1 M 2	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, E 3-3-]	sirth Day, Year)	9. Birthpl Coun	lace (State or Foreign try)
	228–66–3510 Usual Residence of Decedent				3-3-1	1945	ATEC	ginia
		City, Town or Lo	cation				10	Od. Inside City Limits
Director	MD Garrett	Oakland						XXYes 2 □ No
			10f. Zip Code			10g. Citizen of	What Coun	try?
Funeral	706 E. Alder St.	110		550			S.A.	
Fun	11. Marital Status 12. Was Decedent Ever in Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 24 No			lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N Rican, etc.)	lo- 14. Ra Bl.	ace - America ack, White, e	
ğ	3X Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 □ Yes 2 □ No	Specify:		Spec	ify: Wh	nite
Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	pation		16b. Kind of I		
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Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle			
2	Glen Edward ellinger 19a. Informant's Name/Relationship (Type, Print)	1		Thelma			iptrap	·
				and Number or Rura				Code)
-	Bobby Gray/ Brother 20a. Method of Disposition 20b			lat Road,	Oaktan	20c. Location		wn State
	Burial 2 ☐ Cremation 3 ☐ Removal from State		sition (Name of natory or other place	i		200. Location	- Oily of 101	wii, Glate
	21. Signature of Funeral Service Licensee		ver CH Cr . Name and Addre		2010	Goshen	, VA	
	Weeks Mathy	20	3 S. 2nd	St., oak	man Fi	Bezal ₅₅ 5	omes F	P.A.
	23a. Part1. Enter the disease, or complicati — caused the de shock, or heart failure. List only one cause on each line.	,						Approximate
	Immediate Cause (Final	nentra	į.					Interval Between Onset and Death
	resulting in death) a. Due to (or as a conse	-						1150407
	Sequentially list conditions h							
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying.	equence of):					I I	
Examiner	that initiated events							
	Due to (or as a conse	equence of):						
dic	d							
n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of preg	nancy				204 D	ata at daliva	
iciai	in the past 12 months? 1	tal death 3	Ectopic pregnanc Other (specify)	у			ate of deliver onth	ry Day Year
Physician/Medical	9 Unknown		, , , , , , _					
by P	Part II. Other significant conditions contributing to death but not re	sulting in the un	derlying cause give	en in Part I.	23e. Did	tobacco use cor	tribute to the	e cause of death?
	Chropic Kepal Failure	, Ruln	many		1 🗆	Yes 2₽No	3 ☐ Proba	ably 4 🗆 Unknown
Completed	Empolism, metabollic	Acid	05/5		24a. Was		Were autop	sy findings available
Con	/					ormed?	prior to com death? 1 🗆 Yes 2	pletion of cause of
Be (25. Was case referred to medical examiner?			26. Place of Death			100 4	
P	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 [☐ ER/Outpatien	3 □ DOA Oth	er: 4 Nursing Hor	ne 5 🗆 Res	idence 6 □Ot	her (Specify))
	27. Manner of Death 28a. Date of Injury 1 ☑ Natural 5 ☐ Pending (Month, Day, Year)	28b. Time of Injury	28c. Injur Work	y at 2		how injury occur		
cati	2 ☐ Accident investigation			Yes 2 □No				
Certification:	4 Homicide 4 Homicide 4 28e. Place of Injury - At building, etc. (Spec	home, farm, stre cify)	et, factory, office	2	28f. Location (City or To	(Street and Num wn, State)	ber or Rural	Route Number,
ర్థ	29a. Certifier 1 Certifying Physician: To the best of my kr	nowlodge dant	occurred at the cit	- 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my kr 2 ☐ Medical Examiner: On the basis of examiner one) and manner stated.	nation and/or inv	estigation, in my o	ne, date and place, a pinion, death occurre	and due to the ed at the time	e cause(s) and m , date and place,	anner as sta and due to	ated. the cause(s)
Me	29b. Signature and title of certifier		29c. Licenso	e number		29d. Date signe	ed (Month, D	Pay, Year)
	1/41/11/11	mos	no	116180	1		13/10	
2	30. Name and address of person who completed cause of death (Ite	em 23a) (Type. F	Print)	0100	1			
9	Dr. Kenneth Buczynski			n St., o	aklan	d MD	21550	
e	31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature			<u>(411</u>	~ <u> </u>	- 1 - 3 - 0	
ar	FEB - 5 2010 2	A. 100						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Jan 5:22P M Fileen Dodson Taylor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Anundel Medical Center Annapolis Anne Anundel Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min Director 577-20-221 rginia Usual Residence of Decedent 28a-f show 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges 1 Yes 2 No Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2308 Hillman Place 20716 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Finance Counselon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anchie Tylen Muin Many Vinginia Douglas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn Muin / son Hillman Place, Bowie, MD, or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2/3/2010 Burgess, injury 4 Donation 5 Other (Specify) Northern Neck Crematory! 21. Signature of Funeral Service Licensee 721 Elden St. 22. Name and Address of F cility any 20170 Herndon, Adams-Green Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death piration ₽hysician/ 5 pneumonia disease or condition resulting in death) Medical Examiner (or as a consequence of) month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 attending p IF FEMALE: es, outcome of pregnancy

Live Birth 2
Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death signed by the all d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hypertension 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown been si should I Gastrointestinal Glauding 24b. Were autopsy findings available prior to completion of cause of 24a Was an cate has page 2 s prior to complete death? this certificate 2 🗹 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital Be Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{Other (Specify)} Hospital 1 ☐ Yes 2 ☑ No မ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manney of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License numbe 29/2010 MO D60390 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JABER 2001 MEDICAL PARKWAY HNNAPOLIS, MD 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

5 DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Twigg 2010 James Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Regional Medical Center Allegani umberland 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. Month, Day Director MD 204-26-6930 78 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Cumberland MD Allegany 1 🗌 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14501 Brant Road 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in LLS 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ☐ Xio If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced Korean white Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Scared Heart Hosp vice-president Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Calvin Edward Twigg Viola Cecila (Skelley) Twigg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 wife 14501 Brant Road Cumberland Anna Belle Twigg Baltimore, 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Restlawn Memorial Gardens 2/16/2010 MD 4 ☐ Donation 5 ☐ Other (Specify) LaVale 21. Signature of Euneral Service Lansee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 7/1 / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ock, or heart failure. List only one cause on each line set an Death mediate Cause (Final Physician, era Medical resulting in death) Due to (or as a consequence of) Examiner fany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and a sed filled in by the Internal director, page 2 should be detached for use as the burnal-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 🗷 No Other: 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injun 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in the opening it, usual occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ause of death (Item 23a) (Type, Print) 30. Name and address of person who completed -Ivengood reton 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 27,2010 ear **Physician** II:IF WW JAMES Y. TILLERSON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges <u>Future Care-Pineview Nursing Home</u> Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 **X**M 2 □ F Months Days Hours Min SCDirector 08-26-39 249-58-3897 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, In a Medical Exeminar must be notified an once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 XYes 2 No Funeral Director Maryland | Prince Georges Camp Springs 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20748 AZU 7013 Tarquin Avenue 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: þ Specify: **Black** 3 Widowed 4 Divorced Year or Dates. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) DC Public Schools Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ushary Tillerson Thelma Burgess ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7013 Tarquin Ave. Camp Springs, MD 20748 Gertie Cook Tillerson / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 02/01/2010 Brentwood, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Strickland Funeral Services, P.A 6500 Allentown Road, Camp Springs, MD 20748 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cardiac Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner End Stage Parkinson's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Dementia Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1 ☐ Yes 2 🕱 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ■ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State Registrar Date filed (Month, Day, Year) FEB 0 2 2010

axmi N. Berwa, M.D.

29b. Signature and title of certifier

one)

7700 Old Branch Ave. Clinton, MD 20735 32. Registrar's Signature are

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

D-24535

29d. Date signed (Month, Day, Year) 01/52/5010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year · 58PM **Physician** Delbert Leroy Townsend JANUARI 2010 26 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 5. Social Security Number MEDICAL 8. Date of Birth (Month, Day, Year) April 6,1921 9. Birthplace (State or Foreign Country) Kansas . Age (In yrs. last birthday) If Under 1 Year **Funeral** 1 X M 2 □ F Months Days Hours 510-16-8980 88 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10h County per it. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Dog tarment of Health and Mantal Hygiene. Important: If them 27 is martled ofther than "natural", or items 23a or 28a-f show any injury or other traumatic event, in March E-miner must be notified at any injury or other traumatic event, in March E-miner must be notified at 1 ☐Yes 2 No Director Maryland Prince George's Fort Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9602 Wedgewood Place 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Retired 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 1 XIYes 2 Net. If Yes, Give Year or Dates: 1973 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖺 No Specify Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army Colonel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mirle Leroy Townsend 01a VanVleet 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia A. Kaufman-Personal Rep. 1205 Swan Harbour Circle, Ft. Washington, MD 20744 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Kalas Crematory 1/28/2010 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur G Funera Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death lvr Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit law requires that the death certificate be executed NEW MON and (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 🗆 Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has Hospital or Attending Physician; The certificate 2 Z No 1 ☐ Yes 25. Was case refered to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To After this funeral 27. Manner of Death 1 V Natural Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □ Yes death. 2 Accident 24 hours after death Funeral Director: completely filled in by the 6 Gould not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the 29d. Date signed (Month, Day, 29c. License number 29b. Signature and title of certifier

F 6 + 1

State Registrar Date filed (Month, Day,

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend # 9,11,20b, per Fh g901 3/3/10 TT

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ezoel. Thomas, Sr. Month 28 20110 3:00A M Medical 4a. Facility Name (if not institution, give street and number) Southern Maryland Hospital Examiner 4b. City, Town, or Location of Death **Clinton** 4c. County of Death
Prince George's . Sex 1 ፟ M 2 ☐ F 7. Age (In yrs. last birthday) Social Security Number 416-24-9441 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Madrid **Funeral** 8. Date of Birth Months Days Hours Min Director 0/20/1926 Usual Residence of Decedent 28a-f shov 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Prince George's Camp Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5808 Middleton Ct Funeral 20748 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc and Mental Hygiene.
is marked other than "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify:Black 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Supervisor Government Be Page 1 and 2 should be filed of ment of Health and Mental Hyg 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Spencer Thomas Mattie traumatic 19a. Informant's Name/Relationship (Type, Print) 18 Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 2808 Middleton Ct. Camp Springs, MD 20748 Iradell Thomas/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2/22/2010 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 2/8/2010 | Cheltenham, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy St. N.W. Washington, DC 20011 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-transit and resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s performed Yes 2 2**X** No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: မ ER/Outpatient 3 DOA 1 Inpatient 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 5 Pending injury Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29c. License number State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Anollania amma Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manland Medical Conto 0 BALTIMORE If Under 1 Year If Under Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 M 2 XF Months (Month, Day, Year Hours Country) Director NIGERI Usual Residence of Decedent show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 XYes 2 ☐ No PRINCE GEORGE'S LANHAM 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 20706 6105 BOX OAK COURT Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, e ģ 1 Never Married 2 X Married BLACK Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT TEACHER 4 YRS Ith and Mental Hygie 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve မ ARIRIATU RITA EKECHUKWU JOSEPH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SYLVESTER UGOH/HUSBAND 6105 BOX OAK COURT LANHAM, MARYLAND 20706 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Number 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place. UMUOKRIKA, IMO FAMILY PLOT 2/26/2010 22. Name and Address of Facility Signature of Funeral Service Licenses J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence oi) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last burial-1 the attending physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be use as the IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Day 1 ☐ Yes 2 ☐ No 9 ☐ Unknown detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò be 2 No 3 Probably 4 Unknown 1 Yes Completed VRE + E(oli backremia. 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 s performed certificate 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No 1 X Inpatient 2 -ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ☐ Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature, and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 7010 710112602 26 MD

State Registrar

DHMH 17 Rev 7/2009

Greene.

Baltimore MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

32. Registrar's

Dickinson

31. Date filed (Month, Day, Year)

JAN 2 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death [□]2010 Physician 1:35 P_M Eleanor Roosevelt January 27, Vauchn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft. Washington Hospital Ft. Washington Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, March 2, 5. Social Security Numbe 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🕅 F Months Days Hours 76 Washington, D.C. Director 577-42-6421 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be mailfied at Temple Hills Director Prince George's 1 XYes 2 No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20748 2401 Southern Ave., Apt.#202 U.S. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 72 hours after 1 ☐Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 African American 1 ☐ Yes 2 X No Specify: ð 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Magnetic opes. Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor-Inspector Givernment 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lafvette Skinner 2 Mary Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hubert Skinner-Son 16004 Pennsbury Dr., Bowie, MD 20716 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Feb. 4, 2010 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility 2504 28th St., N.E., WDC 20018 Bornette & Assoc. Funeral Home Inc. Approximate Interval Between Onset and Death 23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 5 hr disease or condition resulting in death) End Stage Chronic Lung Disease /Medical Due to (or as a consequence of): Examiner 5 hr Cardiac Arrhythmia Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events requires that the death certificate be executed 10 yr Hypertension burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760. anding physician use as the burial 10 yr Physician/Medical Diabetes Mellitus attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Ö the 1 ☐ Yes 2 🎇 No 9 Unknown signed by t be detach by σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ð 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? autopsy perform page ; certificate 1 □Yes 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 ☐ Pending investigation 1 XNatural death. 1 ☐ Yes 2 ☐ No Il Director: A 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number January 29, 2010 D24535 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laxmi N. Berwa 7700 Old Branch Ave. Ste C-101, Clinton, MD 20735

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 3 2010

32. Registrar's Signatur

State of Maryland / Department of Health and Mental Hygiene -1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** Kenneth D. Weir M 27, January 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 28140 Whitehaven Ferry Road Princess Anne Somerset If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday **Funeral** 293-38-7293 Director 66 08-15-1943 Ohio Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Princess Anne Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 28140 Whitehaven Ferry Road 21853 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Police Officer Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kenneth G. Weir Arlene Voth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carole A. Weir/Wife 28140 Whitehaven Ferry Road, Princess Anne, MD 21853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 01-28-2010 Salisbury, Maryland 22. Name and Address of Facility Hinman Funeral Home Ignature of Funeral Service Licersee M00295 11673 Somerset Ave., Princess Anne, MD 21853 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nediate Cause (Final **Physician** Insease or condition resulting in death) 10911 /Medical Due to (or as a consequent Examiner Darkinson Sequentially list conditions, Dive to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ate has been signed by the page 2 should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 **2** No Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 R/Outpatient 2 1 Tes 1 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō To the Hospital within 24 hours a To the Funeral L Hospitai 11 - ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of sertifier 84 30. Name and address person who completed cause of death (Item 23a) (Type, Print) 30434 Mt. Vernon Road, Princess Anne, MD 21853 Charles B. Hofmann, 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

Registrar DHMH 17 Rev 1/2001

State

REPLACEMENT PER OF Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 21 State of Maryland 37 22/20 10 Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Whaley 12:04PM ichard George Feb 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner Easton albot HUSP Memorial If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/17/1941 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Social Security Number **Funeral** Months Days Hours 1**X**] M 2 ☐ F 221-26-6717 68 Yrs Delaware Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, <u>the Medical Examiner must be notified at</u> Caroline Greensboro 1XYes 2 □ No MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21639 104 North School Street **United States** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1958 1 X Yes 2 No 1962 If Yes, Give 1962 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or her any injury or other traumate. 1 ☐ Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: 1962 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Black & Decker Co. Security Officer GED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fannie Lowe Whaley George ပ 19a. Informant's Name/Relationship (Type. Print)

Joyce Whaley/Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 623, Easton, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place)

Eastern Sh. Veterans Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 02/12/2010 Hurlock, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee Michael F. Eskow per DVR 216 N. Main Street, Federalsburg, MD 21622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** oronary Hrtery *lears* disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): physician s the burial Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death 1 Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Hyporatremia Steep Apnea, Pneumonia Emphesemia Diabetes Anxiety, Demyetration Completed 24b. Were autopsy findings evailable prior to completion of cause of death?
1 ☐ Yes 2 ☑ No Polyneuropathy, Renal In sufficiency Osterarthystis, Major Depression, Chronic 24a. Was an autopsy performed? Produtitis, Post Traumatic Stress Disorder 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number H44615 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Cambridge, MD 21613 LOIS/HNarr DO Bramble 31. Date filed (Month, Day, Year) State MAR 19 2010 Registrar

DHMH 17 Rev 1/2001

Karl Raymond Wilcox

Medical Examiner

Funeral

Physician/

1- For State

KARL

4085 Carrick Ct

167-40-4231

1. Decedent's Name (First, Middle,Last)

RAYMOND

6. Sex

4a. Facility Name (if not institution, give street and number)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

Frederick

WILCOX

7. Age (In yrs. last birthday)

	Director		367 40 4231	1XM 2F	6	60 Yrs.	onths D	ays Hours	s Min.	AUG 8	,1949	9 Fo	reign Country) P	A
2			Usual Residence of Decedent											
)	'an)		10a. State 10b. County		IOc. City	, Town or Location				-				City Limits
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	Maryi 28a-1 d at c	Director	10e. Street and Number			10	f. Zip Code				10g. Citi	izen of What C	ountry?	
	h the	Ö	4085 Carrick	Ct.			2172	27			Unit	ed Sta	tes	
	r items 2	Funeral	11. Marital Status 1 Never Married 2 X Ma	12. Was Decedent E Armed Forces? 1 Yes 2	verin U			Hispanic Orig an, Mexican			No-	14. Race - Ar White, etc	nerican Indian,	Black,
	after (all, or	by F	3 Widowed 4 Div	orced If Yes, Give Year or Dates:	I NO	1 Yes	2 X N	lo s <i>pecify:</i>				Specify:	White	
	natur Xam	ed	15. Decedent's Education (Spec			16a. Decedent's U during most of					16b. l	Kind of Busine	ss/Industry	
036	permit. Fages 1 and 2 snould be tited within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once,	Completed	Elementary/Secondary (0-12)	College (1-4 or 5-	+)	Certifie	_				Ta	x Planı	ning	
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121	ontal ental arked	Be	Russell	Wilcox				Ire		Ε.		schsel		
0.2	snoul nd M is m	٩	19a. Informant's Name/Relations			19b. Mailing Add								
Ξ̈́	alth a		Yvonne Wilcox 20a. Method of Disposition	/ Wife	I 20h ii	4085 Ca				tsbur Date			d 2172 or Town, State	
e .	ages 1 a nt of He nt: If ite other ti		1 Burial 2 X Cremation	3 Removal from Stat		crematory or other p		emetery,	L	Jate	20c. i	Location - City	or rown, State	1
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Salt	permit. Depart Impor injury		21. nature of Funeral Service	ic ee				ss of Facility	Stat			ral Ho	me	
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	ysician Iedical		failure. List only one cause	on each line.			ode or dyin	g, such as ca	ardiac or re	espiratory a	irrest, sno	ock, or neart	Between	ate Interva Onset and
	aminer		Imm-ciate Cause (Final disease or condition resulting in death)	a Diabetic k									J	eath
		- 1		Due to (or as a consec	uence o	τ).								
		힏	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	uence of	f):								
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	C		0								
3	nsit	Ä	events resulting in death) Last	Due to (or as a conseq	uence of	T):								
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876	ng ph as the	2	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	or pregi	nancy 2 Fetal de	eath 3	Ectopic	pregnanc	y		d. Date of deliv	ery Day	Year
ords, P.O. Box 68760,	w requires that the death centurate be executed is been signed by the attending physician and should be detached for use as the burial - transit	Physician/Medical		4 Pregnant at ti	me of de	ath 5 Other (Specify)				- 1			
8 §	the a		1 Yes 2 No 9 Unk	9 Unknown										
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of Vital Records,	After this certificate has uneral director, page 2 s	B	examiner?	Hospital: 1 Inpatient	2	ER/Outpatient 3	DOA	Other4	Nursing F	lome 5	Resider	nce 6 🗸 Ot	ner Scene	
اً ح	After t	<u> </u>	27. Manner of Death	28a. Date of Injury (Month, Day,Yea		28b. Time of Injury	28c. Inj	ury at Work	? 28	d. Describe	e how inju	iry occurred		
ion	eath. tor: ,	읥	1 X Natural 5 Pendi 2 Accident Invest		,		1	Yes 2	No					
Division	ufter d				y - At ho	ome, farm, street, fac	tory, office	building, etc	c. 28	f. Location or Town,		nd Number or	Rural Route Nu	mber, City
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Division of Vital Reco	hin 24 hours after death. the Funeral Director: Anpletely filled in by the fu	lical		ysician: To the best of my l										
Ž	P P P	품티	one) 2 Medical Exan	iner:On the basis of exami	nation ar	nd/or investigation, i	n my opinio	in, death occ	curred at th	e time, dat	e and plac	ce, and due to	the cause(s)	

OCME

Reg. No.

4c. County of Death

Frederick

29d. Date signed (Month, Day, Year)

January 31, 2010

Month Day January 30, 2010

If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or

3. Time of Death

2043 hrs

2. Date of Death

State Registrar

29b Signature and title of certifier

31. Date filed (Month, Day Year)

Ling Li, MD

30 Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

29c License number

O.C.M.E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of De Physician/ Month William 2010 Walker January 3:29 P^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Airy Frederick Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Dec. 19, Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 ☑ M 2 □ F Days Country) Ohio **Director** Yrs 283-20-6477 Dec. 84 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f s injury or other traumatic event, the Medical Examiner must be notified 1 🗆 Yes 2 🔯 No Maryland Frederick Ijamsville 10e. Street and Number 10g. Citizen of What Country? **Completed by Funeral** 11414 Meadowlark Drive 21754 United States 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married X Yes 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Cabinetry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ William H. Walker Ruth Mazwell Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other tratonce. Gail Ali (daughter) 1414 Meadowlark Drive Ijamsville, MD 21754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Stauffer Crematory 02/01/2010 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes Signature of Funeral Service Licensee acas Opossumtown Pike Frederick, MD 33a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line the death Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) ADENOCARCINOMA Physician/ OF Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year 1 Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 No KUNG HOUSE 1 Tes Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check D31761 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOI W. SEVENTH ST. NNOR 4+1VA 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JOHN RICHARD WHITE 01 8:30 P M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GILCREST HOSPICE CARE TOWSON Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) 05-05-1929 1 X M 2 🗆 F Months Days Hours Min. Director <u> 189-22-2429</u> 80 Usual Residence of Decedent 28a-f shov 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 X No MD TALBOT BOZMAN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22490 INDIAN POINT ROAD 21612 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 Divorced Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) DIRECTOR OF PERSONNEL PHARMACEUTICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BRENDAN NICHOLAS WHITE MARGARET POWERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CONSTANCE IVEY/DAUGHTER 506 EMILY CIRCLE, WEST CHESTER, PA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State CHESAPEAKE CREMATION FEB.3,2010 CENTER 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 MAN R. MERCERO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Enysiciana nomic disease or condition Trav Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of it on, keeing to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No signed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page performed' 1 Yes 2 X No Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 💢 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 😿 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work hours after death. neral Director: Aft illed in by the fur М 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

W

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

arves

MARION

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

, g	day 6	-
Reg. No.	U	U

			1 = For State Registrar	Ce	rtificate of	Death	Re	g. No. 201	0 04792
	Dhuaisi		1. Decedent's Name (First, Middle, Last)				2. Date of Death	1	3. Time of Death
	Physicia /Medic		ELIZABETH B. WESLEY				JANUARY	28, 2010	4:30 A M
	Examin		4a. Facility Name (If not institution, give street and no	mber)	4b. City, Town, o	or Location of Death		4c. County of D	eath
			WILLIAM HILL MANOR		EAST			TALBOT	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🔏 F	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, UNE 29,	Year) 9. 1 1912 M	Birthplace (State or Foreign Country) ARYLAND
	pu ,		Usual Residence of Decedent	40a City Tayya ar la	- antion				10d. Inside City Limits
	show	'n	10a. State 10b. County	10c. City, Town or Lo	ocation				1 XYes 2 □ No
	8a-f	Directo	MARYLAND TALBOT	EASTON	1 =				
	ith th	Dir	10e. Street and Number		10f. Zip Code	_		g. Citizen of What	
	ath w	ral	1175 S. WASHINGTON ST.,		2160			JNITED ST	
	er de	Funeral	Armed Fo	edent Ever in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto F	city Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the W. Clexil Evan in the intilling at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, G Year or D	ve	1 □Yes 2 No	Specify:		Specify: W	HITE
5-	72 h 'natu	ete	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occu kind of work done	during most of working		6b. Kind of Busine	ss/Industry
121	rithin ne. han '	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retire	d) -		OTHE HOM	no
2	led w lygie her tl nt, th		12	HOM	EMAKER	40 Mathada Nama	/First Middle M	OWN HOM	IB .
and	should be filed vand Mental Hygies marked other taumatic event, In	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		iaiden Sumame)	
<u> </u>	ouid I Mer narke	ြ	ISAAC BRADBURN			MARTHA P			
Maryland	2 sho h and is ma rauma		19a. Informant's Name/Relationship (Type. Print)			and Number or Rura		-	
	1 and 2 Health em 27 i		E. JAYNE WESLEY/DAUGHTE					20c. Location - City	N, MD 21601
altimore,	ai O		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	State 20b. Place of Disponent CHESAPEA CENTER	matory or other pla KE CREMA	FEB 1		STEVENSVI	
Balt	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licensee		2. Name and Addre	ess of Facility HELFENBEIN RRISON STR	& NEWNA	AM FUNERA	L HOME, P.A. 21601
			23a. Part 1. Enter the disease, or complications that	caused the death. Do not en					Approximate Interval Between
1	Physician		shock, or heart failure. List only one cause on a Immediate Cause (Final	each line.	Out	100,000	1/00	m L	Onset and Death
1	/Medical		disease or condition resulting in death)	(or as a consequence of):	1200	viro vous	00 0		re la vois
A	Examiner			all Dis	1 / who	mei	MON	1. 1.	31000
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a consequence of):		- V	7	VO 1-	70000
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	U					
Ċ,	exection and ital-tra	Exa		(or as a consequence of):					
68760,	icate be executed physician and the burial-transit	ca	L d.						
.89	ertifical ling phy e as th	Medical							
ŏ	eath cer attendin for use		IF FEMALE: 23c. If yes, ou	tcome of pregnancy	75			23d. Date of	delivery
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician	in the past 12 months? 1 ☐ Live	nant at time of death 5	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	cy 	·	Month	Day Year
P.0	that the de ned by the detached	Phy	9 🗆 Unknown	n			00- Did t-b		a to the server of death?
	signed	þ	Part II. Other significant conditions contributing to d	eath but not resulting in the u	inderlying cause gi	ven in Part I.	1		e to the cause of death? Probably 4 Unknown
oro	w requir s been s should	Completed	1 Sevil Eller of	- coop was	vec		1 10 16:	5 2 100 3	
ec	law lasb	ed l	- mangen	Α	•	1	24a. Was an autopsy perform	24b. Were	autopsy findings available to completion of cause of
<u> </u>	fan: The latificate hator, page	5	Voes cular	10 Clush	w 15	arilling (perform 2	ned?// death	n? Yes 2 □ No
/ita	Physician: r this certific ral director, I	Be (25. Was case referred to medical examiner?			26. Place of Death	(Check only one	e)	
=	hysic his c		1 Yes 2 No Hospital: 1 □	Inpatient 2 ER/Outpatie	III 3 L DOA		ne 5 🗆 Reside	nce 6 □Other (S	Specify)
n c	ng P	ü	27. Manufer of Death 28a. Date 1 ☑ Natural 5 ☐ Pending (Mor	of Injury 28b. Time of Injury Injury	Wo		8d. Describe ho	w injury occurred	
9	endi eath. or: A the fu	ati	2 Accident investigation]Yes 2□No			
Division of Vital Records,	r Att	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined build	of Injury - At home, farm, string, etc. (Specify)	reet, factory, office	2	8f. Location (Str City or Town,		r Rural Route Number,
	ital o rs aff al Di led ir	S							
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical	29a. Certifier 1 Certifying Physician: To the (Check only one) 2 Medical Examiner: On the and mar						
	To the within To the compl	Me	29b. Signature and title of certifier	1//(/ / / / /	29c. Licen	se number	29	od. Date signed (M	onth Day, Year)
	15		William	H Wood 1	11)	108713	>	1/28	110
	gars		30. Name and address of person who completed cau	se of death (Item 23a) (Type, DUTCHMAN S LA		ON MD 21	601		
				Begistrar's Signature	ure, sasi	ON, MU ZI	001		
	Sta Registra		FFR 0.1 2010		a. V. J				

10-01053

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Daniel Wilt	1- For State Registrar	tate of Maryland	/ Department of Certificate of		Mental Hy		eg. No. 201	0 0479
Physician/ Medical Examine	Decedent's Name (First, Midel Daniel Wayne	Wilt				Date of Deat Month February 5	h Day Year 5, 2010	3. Time of Death 1220 hrs
	4a. Facility Name (if not instituti 157 Blaine Wilt Lane			4b. City, Town, or Lo Accident			4c. County of De Garrett	
Funeral Director	5. Social Security Number 217–76–9642	6. Sex 7. Ag	ge (In yrs. last birthday) 48 Yr	Months Days s.	If Under 24Hrs. Hours Min.	1	10, 1961	reign Country) Maryland
d d	Usual Residence of Decedent 10a. State 10b. County MD Ga	rrett	10c. City, Town or Local	tion				10d. Inside City Limits 1 Yes 2 X No
the Maryland a or 28a-f show any tified at once. Director	10e. Street and Number		nooraciie	10f. Zip Code		10	0g. Citizen of What C	ountry?
or items 23s or 28s-f sho nust be notified at once. Funeral Director		12. Was Deceden Armed Forces		21520 as Decedent of Hispa Yes, specify Cuban, N			USA - 14. Race - Am White, etc	nerican Indian, Black,
	3 Widowed 4 X Di	vorced If Yes, Give Year or Dates: ecify only highest grade cor	mpleted) 16a. Decede	Yes 2 X No s	n (Give kind of wo		Specify: W	hite ss/Industry
5-0036 Iled within 72 hour Hygiene. I other than "matur the Medical Exam Completed.	Elementary/Secondary (0-12	2	5+)	echanic			Marine S	Service
21215-00; ould be filed with I Mental Hygiene; marked other to it event, the Mental To Be Com	Plaine Compa	Martha H	Elizabe	th Prestor				
	Jesse D. Wilt/ 20a Method of Disposition	lt Lane	Accid	ent, MD 2 20c. Location - City	21520 or Town, State			
Baltimore, MD oemit. Pages I and 2 sho opentment of Health and Important: If item 27 is njury or other traumati	1 X Burial 2 Crematic 4 Donation 5 Other S 21. Signature of Funeral Service		O Bitting					
M 됩러트로 Physician	23a. Part I. Enter the disease, diallure List only one causi	5, Grant ich as cardiac or	sville respiratory arre	MD 2153 est, shock, or heart	Approximate Interval Between Onset and			
Examiner	Immediate Cause (Final diseas or condition resulting in death)		erotic card		r diseas	e comp1	licated by	Death
ited d ansit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons d.						
760, cate be executed physician and the burial - transit	X UNPENDED IF FEMALE: 23b. Was decedent pregnant in	AMENDED 23a					23d. Date of deliv	
2.O. Box 68760 that the death certificate the by the attending physicianhold by Physician/Me by Physician/Me	past 12 months? 1 Yes 2 No 9 Ur	I LIVE DIGIT	t time of death	etal death 3 ther (Specify)	Ectopic pregnan	cy	Month	Day Year
ires that the signed by the detache		tions contributing to dear	th but not resulting in the	underlying cause give	en in Part I.	23e. Did to		to the cause of death? Probably 4 Unknown
cords aw requals been 2 should				M		24a. Was a autope perfor	sy prior t med? death	autopsy findings available to completion of cause of 1? Yes 2 No
F Vital Rec Physician: The I ar this certificate I al director, page To Be Com	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Outpatien	t 3 DOA	_	Home 5	Residence 6 🗸 Ot	
Division of N Spital or Attending Phy tours after death. neral Director: After ti filled in by the funeral Certification: Tr	27. Manner of Death 1 Natural 5 Per 2 X Accident investigation	28a Date of Inj (Month, Day) Fd 2/5/ 280 Place of Inj	Injury 28c. Injury at 1 Yes	s 2 X No	environ			
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the edical Certificatti		ild not be	sidence		Į į	Acciden	t, MD	Rural Route Number, City ine Wilt Landard Witten
To the Ho within 24 To the Fu completely	one) 2 Medical Ex	aminer: On the basis of exa			leath occurred at			the cause(s)
OCME	30. Name and address of perso	n who completed cause of	death (Item 23a)	O.C.M.	.E.		February 8, 20	10
State	Mary G. Ripple MD. 31. Date filed (Month, Day, Year		ical Examiner 11	1 Penn Street, E	Baltimore, MD	21201		
Registral DHMH 17 Rev 1/2001	FEB - 92	UIU	ORIGINA	\L				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** HOWARD GEORGE WEINELT FEB.10 2010 8:20A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14204 BRANDYWINE HEIGHTS RD. BRANDYWINE P.G. 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-2-1942 9. Birthplace (State or Foreign **Funeral** 1√2 M 2□ F Months Days Hours Min. 67 WĂŚĦ.,D.C. **Director** 214-42-7388 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c, City, Town or Location 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Madical Evaninar must be notified at MD. Director PRINCE GEORGES BRANDYWINE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14204 BRANDYWINE HEIGHTS RD Funeral 20613 S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Was Decedent L... Armed Forces? 1 ☑Yes 2 ☐ No NAVY 1 Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married ,00 Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify <u>۾</u> Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) GODDARD SPACE Elementary/Secondary (0-12) College (1-4or 5+) Hygiene FLIGHT CENTER ELECTRONICS TECH. h and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe HOWARD FRANK WEINELT 0 BERTHA MARIE SHLAGEL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health at Important: If item 27 Is any injury or other trau THELMA ROSE WEINELT-SPOUSE 14204 BRANDYWINE HEIGHTS RD.BRANDYWINE Baltimore, 20c. Location - City or Town, State 0613 20a. Method of Disposition 20b. Place of Disposition (Name of Date ST. PETERS CEMETERY 2-18-2010 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State WALDORF, MD. 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licensee MQ0479 Name and Address of Facilit RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** andiac disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 D Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 ☑No Physician; The certificate 1 ☐Yes 2 ☐No Division of Vital 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 - Natural 5 Pending investigation injury death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu the

State

Medical

29a. Certifier (Check only one)

31. Date filed (Month,

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Timoth

PACE

32. Redistrar's Signature

Registrar

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c, License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JANUARY 2010 35A WHITE MARTIN Luther Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEMORTAI | 6. Sex If Under 24 Hrs Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗶 M 2 🗆 F West Virginia Months Days 5/14/1934 231-38-7069 75 **Director** Usual Residence of Decedent or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland must be notified at Director 1 🗆 Yes 2 🕅 No MD Carroll New Windsor 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Iral", or items 23a Examiner must be 21776 United States 1596 Smiley Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Was Decess? Armed Forces? 1 ☐ Yes 2 No Black, White, etc. ģ 1 ☐ Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Asplundh Elementary/Seconday (0-12) College (1-4 or 5+) Tree Surgeon Tree Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental F other traumatic <u>Nannie B. Tharpe White</u> <u>Robert Lee White</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 i转 1596 Smiley Dr. New Windsor, MD 21776 Betty L. White Wife Department of Heali Important: If item 2 any injury or other once. Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pleasant View 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/4/2010 Martinsburg, 22: Name and Address of Facility Jefferson Chapel Funeral Home Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not inter the mile of hing, such as contact or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ acr disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death
9 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be 1 Tes 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director: A ☐ Accident ☐ Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

Sorre

Registrar's Signature

7th St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month FEBRUARY CALVIN FLOYD WICKHAM 05.15 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK VINDOBONA NURSING HOME FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday, Hours 1 X M 2 D F (Month, Day, Year) UGUST 6 Country) MARYLAND 219 14. 9882 Director 88 Usual Residence of Decedent show 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Jefferson Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4216 Gene Hemp Road 21755 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 X Married "natural", or Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation

'Give kind of work done during most of working other traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Dairy Farmer Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe Harry F. Wickham Mable M. Gant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Betty Lee Wickham / Wife 4216 Gene Hemp Road, Jefferson, Maryland 21755 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) February 18 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mark's Cemetery Petersville, Maryland 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Licer 22. Name and Address of Facility
Keeney & Basford PA Funeral Home
106 East Church Street, Frederick MO1473 Maryland 2170 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEMT FAILMO Ph_sician/ CONGESTIVO monty disease or condition Medical resulting in death) Due to (or as a consequence of) ⁻∕Examiner 2 years Anteny - O RANARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of) the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 1 \square Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed death? 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical l a 26. Place of Death (Check only one) examiner? 2 🗆 No Other: 뎯 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certification 29c. License number 22037 2-15-2010

Registrar

Brunewick

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

610

32/Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Mai	rylanu / i		rificate of D		u ivien		jierie Reg. No.	001/	01707
			1. Decedent's Name (First, Middle, Las	st)						Date of Deat	th	2011	3. Firme of Death
	Physicia Medic		Joyce V. Wil:	son					Jа	Month Inuary	31	, 2010	1:44 PM
	Examin		4a. Facility Name (if not institution, give	street and number)			4b. City, Town, or	Location of De			$\overline{}$	County of Deat	h
			1256 Palmer Roa	ad			Fort Wa	shingt	on		Pr	ince Ge	orges
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last birt	thday)	If Under 1 Year	If Under 24 F	Irs. 8. D	ate of Birth	1	9. Birt	hplace (State or Foreign
	Director		5//-56-6004	□ M 2 🖾 F	67	Yrs.	Months Days	Hours M	$\frac{1}{9}$	Month, Day,	942	Was	hington. DC
	d t w		Usual Residence of Decedent 10a. State 10b. County		0c. City, Tow		otion				_		40d Incide City Limite
	ylan f sh ed a	cto											10d. Inside City Limits
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	th the	Funeral Director	10e. Street and Number				10f. Zip Code				10g. Citi	zen of What Co	untry?
	th wit	ner	1256 Palmer Roa			1	20744		(B) (B)			US	
	deat r iter		11. Marital Status	12. Was Decedent Eve Armed Forces?		13. W	as Decedent of His Yes, specify Cubar	spanic Origin? n, Mexican, Pu	(Specify Yuerto Ricar	es or No- n, etc.)		 Race - Ame Black, White 	
36	after al", o xam	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 🖾 No If Yes, Give	0	1	☐ Yes 2 🙀 No	Specify:				Specify: Bla	ack
21215-0036	atura cal E	Completed	15. Decedent's E	Year or Dates.	16a	Decede	ent's Usual Occupa	ation			16h Kir	nd of Business	Industry
5	72 h	d l	(Specify only highest gr			(Give ki	nd of work done di NOT use retired)	uring most of v	working	- 1	TOD. KII	nd of Edsiriess	industry
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ğ	iled v othe /ent,		17. Father's Name (First, Middle, Last)		•			18. Mother's I	Name (Firs	t, Middle, N	<i>Maiden</i> S	Surname)	
<u>a</u>	l be f lenta rked tic e	욘	George Edward	Knight				Josep	ohine	Dys	on		
Maryland	hould and N s ma uma		19a. Informant's Name/Relationship (7	ype, Print)	19b	o. Mailing	Address (Street a					Town, State, Zip	Code)
Σ	d 2 salth a alth a 127 i		Rosalind Wrigh	it / Daught	er 9:	302	Ivanhoe 1	Rd. For	rt Wa	shing	ton,	MD. 2	20744
ē,	1 and 1 and		20a. Method of Disposition		20b. Place o	f Dispos	ition (Name of atory or other place		Date			cation - City or	Town, State
Ë	Page nent c		1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spe		Fort				3/201	0	Bren	ntwood,	MD.
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature f Funeral ryl en	see	1010		Name and Addres						
m	permi Depar Impo any ir once.		Vulta Ma	icis			01 Blade						20722
			23a. Part 1. Enter the dis as , or com shock, or heart failure. List only of	plications that caused the	ne death. Do r	not enter	the mode of dying	, such as card	diac or resp	oiratory arre	est,		Approximate Interval Between
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	Medical		resulting in death)	a. Due 🖟 (or as a c	consequ a ce	of):	•						
	Examiner		Sequentially list conditions.	- Just	XITE	wa	LOW						
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687			IF FEMALE:							- 10		-	
9×	death certif he attending ed for use a	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2	Fetal deat		Ectopic pregnancy	У			2	23d. Date of del	*
Bo	5 2 3 1	Physician/M	in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	ime of death	5 🗆	Other (specify)					Month	Day Year
P.O. Box	requires that the de been signed by the should be detached	Ph	Part II. Other significant conditions of	ontributing to death but	not resulting	in the un	derlying cause give	en in Part I.		23a Did to	hacco us	se contribute to	the cause of death?
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jor	tend death tor: /	tific	2 Accident Investigatio 3 Suicide 6 Could not be	0	. At home fo			Yes 2 No	-				(D + N - (
Division of Vital Records,	or Attend after death Director: A in by the f	Cer	4 Homicide determined	28e. Place of Injury building, etc.	Specify)	irm, stree	ет, тастогу, опісе			ocation (St City or Town		l Number or Rui	al Route Number,
Ω	pital ours a eral [29a. Certifier 1 Certifying Phy	sician: To the best of m	v knowledge	death or	cured at the time	date and place	e and due	to the cau	ee(e) and	d manner ae eta	ted
	Hos 24 h Fun eted	Medical	(Check 2 Medical Exam		mination and/o	or investi	gation, in my opinio	n, death occurr	red at the ti	ime, date an	d place,	and due to the	ause(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	2	only one) 3 ☐ Certifying Nur 29b. Signature and title of certifier	oo . racacher, to the be	o. or my miow		29c. License		piace, and			e signed (Month	
			Public Mi	D			Sm	557 F	5		(9	92/02	10
1-	M		30. Name and address of person who	completed cause of dea	th (Item 23a) ((Type, Pr	int)	<u> </u>	<u> </u>	1		ot .	· .
R	- 1		Lenry John	6104 01	d boyo	ma	h Aven	ue i	1em	ple	Hi	M cell	D 20748
	Stat		31. Date filed (Month, Day, Year)	32. Regis rar's	s Sic lature	1				1		V	
	Registra	ar	LER A S SAIN	were to	7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** ILLIAM 2010 EILA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Hospice House Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1□M 2**Z**F Director 22 579-78-5369 1957 DC Nov. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1⊈Yes 2□No Director Maryland Prince George's Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8106 Gorman Avenue # 324 20707 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 X Never Married 2 ☐ Married 1 ☐Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🛣 No Specify: ģ 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r filed within I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Drug Counselor Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard L. Hodges ပ Gloria J. Bowen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important; If item 27 is r any injury or other traun 5329 Brewer Rd. Richard L. Hodges/ Father Beltsville, Md. 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition February 8 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 Harmony Memorial 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee MANI 4001 Benning Rd. NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** MONTO disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unidentifing Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physician and for use as the burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Vear 5 Other (specify) P.O. the □IInknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 2 No 1 ☐Yes 2 🗆 No 1 □ Yes or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral Hous 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending Injury ithin 24 hours after death.

the Funeral Director; Aft
ompletely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Dimedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated.

State Registrar

within 2 To the I

31. Date filed (Month, Day, Year) FEB 0 2 2010

29b. Signature and title of certifier

MU

Name and address of person who completed cause of death (Item 23a) (Type, Print).

Name and address of person who completed cause of death (Item 23a) (Type, Print).

Name and address of person who completed cause of death (Item 23a) (Type, Print).

Name and address of person who completed cause of death (Item 23a) (Type, Print). 32. Registra 's Signa re

29c. License number

21438

29d. Date signed (Month, Day, Year)

28 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	. •	For State Registrar	State of Marylai		rtificate of C			ene .g. No. 2010	04799		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year	3. Time of Death						
*	Medic Examin	al	4a. Facility Name (if not institution, give s	treet and number)		4b. City, Town, or	Location of Death	Jan	29 70) (4c. County of Dea			
			Washington Adven				oma Park		Montg	omery		
	Funeral Director		5. Social Security Number 578-64-2318 Usual Residence of Decedent	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 2	^{year)} 1947	thplace (State or Foreign buntry) DC		
	land show dat	tor	10a. State 10b. County		ity, Town or Lo	ocation				10d. Inside City Limits		
	Mary 28a-f	.≒	Maryland Prince Ge	eorge's		T	Oxon 1		1 № Yes 2			
	vith the 23a or st be	aral [301 Ferndale P	lace		10f. Zip Code	20745	11	og. Citizen of What Co United S			
036	within 72 hours after death with the Maryland jiene. or than "natural", or items 23a or 28a-f show than "natural", are items 25a or 26a-f show the Medical Examiner must be notified at	ed by Funeral		12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛛 No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	erican Indian, e. etc.		
2-0	2 hour "natu edical	plet	15. Decedent's Edu (Specify only highest grad		(Give	ecedent's Usual Occupation 16b. Kind of Business Industry live kind of work done during most of working						
121	within 7 giene. ner than t, the Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. L	OO NOT use retired) Houseke	_	Private				
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ryla	should be file and Mental 7 is marked c raumatic eve	<u>F</u>	Clyde Ware 19a. Informant's Name/Relationship (Typ	e Printl	405 14-11	in a Address (Otes to	and November and Door	Helen Bryson ural Route Number, City or Town, State, Zip Code)				
Ma	d 2 shou alth and n 27 is m er traum		Priscilla Hines/			Ferndale				745		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should by Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		Place of Disp cemetery, cre	osition (Name of matory or other plac		ary 5,	20c. Location - City or	Town, State		
ΞĦ	artmen artmen ortant: injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Si ature of Funeral S ice Licture			Memorial		010	Landover, neral Home	Maryland Tro		
Ba	permi Depar Impor any ir	()	21. Signature of uneral street Lie se	igton, DC	20019							
	Pnysician/ Medical Examiner	ner	23a. Part 1 Exter the disease, or complishock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	cations that caused the dea e cause on each line. Due to or as a consecuence. Due to (or as a consecuence).	ulmo quence of):	ter the mode of dying	ARRE.	or respiratory arres	st,	Approximate Interval Between Onset and Death		
092	ificate be executed ig physician and as the burial-transit	ledical Examiner	cause, Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a consect	quence of):							
Box 68	death cert ne attendir ed for use	≥	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	3c. If yes, outcome of pregn 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	☐ Ectopic pregnanc☐ Other (specify)	у		23d. Date of de Month	elivery Day Year		
s, P.O	ires that the dee n signed by the a ld be detached t	by	Part II. Other significant conditions con	tributing to death but not re	esulting in the	underlying cause giv	en in Part I.		acco use contribute to s 2 ⊠ No 3 □ F	o the cause of death? Probably 4 \square Unknown		
Division of Vital Records, P.O.	Physician: The law requires that the this certificate has been signed by the rail director, page 2 should be detach	Completed						24a. Was an autops perform 1 \(\sum \) Yes 2	y prior to death?	utopsy findings available completion of cause of		
tal	cian: T	Be	25. Was case referred to medical examiner?	ospital:			ace of Death (Chec		1110			
of Vi	g Physi ar this c eral dir	P 1 1 Inpatient 2 IM ER/Outpatient 3 1 DOA 4 Nursing Home 5 Residence 6 Other (Specify)								cify)		
ouo	Attending er death. ector: After by the fune	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work	? Yes 2 ☐ No	_				
Divisi	al or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci		reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ural Route Number,		
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical	(Check 2 Medical Examin	cian: To the best of my knower: On the basis of examination Practioner: To the best of r	on and/or inve	stigation, in my opinio	n, death occurred a	t the time, date and	place, and due to the	cause(s) and manner stated.		
	To the within 2 To the comple		29b. Signature and title of certifier	10		29c. License D 46S	number 29	29	ANUAR	31 2-010		
R	2		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type,	Print) NER PARY	WAY GR	E Coy BEL	7 MARYL	Areo 20770		
	Sta Registra		31. Date filed (Month, Day, Year) FER 0 2 2010	32. Registrar's Sign	ature					-		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MALKER Month YERMON 12:14 AM MAL 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F Days Hours Director 218-20-0235 83 MAY 19 1926 OHIO Usual Residence of Decedent 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it e Madical Examinar must be notified at 10d. Inside City Limits Director 1X Yes 2 □ No PRINCE GEORGE'S BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 12301 DUCKETT TOWN ROAD 20719 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No \$ Specify: BLACK Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH <u>CLAIMS EXAMI</u>NER GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental | ant: If item 27 is marked o SAMUEL WALKER EDITH PARM ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21042 SHELIA A WALKER-PEACO/DGT 2907 POLAND SPRINGS DRIVE ELLICOTT CITY, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND NATIONAL CEME 2/1/10 LAUREL, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Line only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC **Physician** disease or condition resulting in death) *∳* /Medical Due to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed COPP burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician FIBRILLATION Physician/Medical attending physi for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 ☐Yes 2 ☐ No 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be DIZEASE RENAL 1 ☐ Yes 2 🔀 🕽 No 3 Probably 4 Unknown DIZBATE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 2**√** No 2 **X**000 1 ☐ Yes 1 TYes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 Pending investigation ours after death.
neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0062704 PHYSICA empleted cause of death (Item 23a) (Type, Print) KARTIK J_{ullet} 30. Name and address of person who d · DESAD MOH City MD 21043 Ridge 3290 190 Road Swite 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

				For State Registrar	Plea				nd / De		ent of H	lealth		III Copie Mental Hy	/giene	e2 0	3 200	0480	
				Registrar Decedent's Nam	e (First, Middle	, Last)					110 07 2	Journ		2. Date of De	Reg. N	0.		3. Time of Death	
		Physicia Medic		ELSIE	3	R.	WY	NN						Month .TANUA	RY 2	ay 24 20	Year		М
4		Examin		4a. Facility Name (iff		_					ty, Town, or		of Death		$\neg \neg$	c. County		1	
		Funeral Director		5. Social Security N 578-38-5		6. Sex	7. Ag	ge (In yrs. I	as <i>t birthd</i> a Yrs	Month	der 1 Year s Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bi	rth a <i>y</i> , Year)	29	g. Birtl Cou WASH	nplace (State or Foreigntry) HINGTON, DC	gn
		WC		Usual Residence of	Decedent			T											
	Marylano	28a-f sho	Director	10a. State MD	10b. County PRINC	E GEORG	GE'S		y, Town or AUREI									10d. Inside City Limit 1 Yes 2 □ I	
	vith the I	23a or 2 st be no	eral Di	10e. Street and Nur 9010 BRI		T TANE	# 201				Zip Code 20708				10g. C	Citizen of V	What Cou	untry?	
986	s after death v	Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status 1 Never Marr 3 Widowed	ied 2 🗌 Mari	12. Was Arm 1 If Ye	s Decedent ned Forces? Yes 2 2 es, Give r or Dates.	Ever in U.S	S. 1	3. Was Dec If Yes, sp				ecify Yes or No Rican, etc.)		14. Race	k, White		
Maryland 21215-0036	nin 72 hours	ne. han "natur e Medical l	Completed	(Spe	ecify only highe	nt's Education st grade comp		5+)	i (Gi	cedent's Usive kind of v	vork done d	ation luring mo	st of work	ing	16b.	Kind of Bu	usiness li	ndustry	
5	d with	lygier ther t nt, th	Be C	8TH 17, Father's Name ((T') A 6'-1 11- 1				WA]	TRESS	S					PRIVA			
20	se file	red of	10 B	,	JOSEPH	,							her's Nam INIE	e (First, Middle BRADSF		n Surname))		
2	ould t	mark mark		JOSHUA 19a. Informant's Na)	-	19b M	ailing Addre	ess (Street a			al Route Numb		or Town S	itate Zin	Codel	_
	and 2 sh	Health ar em 27 is ther trau		DIETRA F	ROGERS/			100, 5	100	000 ВЕ	RUNSWI		VENU	E #311	SIL	VER S	SPRI	NG,MD 2091	.0
Raltimore	Page 1	nent of H ant: If ite ıry or ot		20a. Method of Disp 1 A Burial 2 4 Donation	☐ Cremation	3 ☐ Remova Specify)	l from State	, 0	cemetery, c	sposition (N crematory o F HEAV	r other plac	e)		Date /2010	1		•	Fown, State LNG • MARYLA	ND
<u>+</u>	permit.	Departin Importa any inju	1 S 2 7	21. Signature of Fu	neral Service L	icensee	00				and Addres		,					AL HOME D 20785	
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2		ysician/		Immediate Cause ((Final	willy offe cause	/ / / A	16	CA	NCE	-D							Interval Between Onset and Death	
1		Medical xaminer		resulting in death)		f . D	ue to or as	a consequ										<u>, , , , , , , , , , , , , , , , , , , </u>	
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	executed	ian and urial-transit		that initiated event resulting in death)	s	c	ue to (or as	a consequ	uence of):										
68760	ate be	physici s the bu	edic			d											\perp		_
B	death	attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 I 9 Unknown	months?	1 4	es, outcome] Live Birth] Pregnant :] Unknown	2 Feta	al death	3 ☐ Ectopi 5 ☐ Other		у				23d. Dat Mo	te of deli	very Day Year	
3010 PD	uires that ti	been signed by the should be detached		Part II. Other signif	ficant condition		-		_		. 1							the cause of death?	wn
1/24/ 2010	The law rec	ate has page 2	Completed by											24a. Was auto perf		<i>\</i> 5	orior to c death?	opsy findings availablompletion of cause of	le f
	cian	nis certificate director, pag	Be	25. Was case referre examiner?		Hospital:					26. Pla		ath (Check	(only one)					
045b	ling Physi	g: B	ate: To	27. Manner of Deatl	5 Pendin	28a.	1 ☐ Inpat Date of inju (Month, Da	ury	ER/Outpa 28b. Time injur	У	28c. Injury work	4 <u></u>		me 5 Resi 28d. Describe				Hospic	E
DIKED OF	or Attend	after deatl	Certificate:	2	investion 6 □ Could determ	not be 28e.	Place of Inj building, et			M street, fact		Yes 2	\rightarrow	28f. Location (City or To			er or Rura	al Route Number,	
30	Hospital	within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical		Certifying Medical E	xaminer: On t	he basis of e	examination	n and/or in	vestigation,	in my opinio	n, death o	occurred at		and plac	e, and due	to the c	ause(s) and manner sta	ated.
WYNN	To the	within To the сопр	2	29b. Signature and		2	To tile	. 2001 01 11!	,omeag		9c. License		(27	2				Day, Year)	
	A	_5		30. Name and addre	ess of person	who completed	d cause of c	death (Item	23a) (Typi	e, Print)	-40	<u> </u>		-7	·	71	~ ;-		
ELSIE		Stat	te	31. Data filed (Mont	h, Day, Year)	10	32. Registr	ar's Signa	ture	PFIR	E,C	060	MB	A,N		21	HE	-	
Ш		Registra	ar	ONIE Z S	2010	Genera	- > A.	h	ales	,						_			

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		ŀ	. 101	partment of Health and Me <i>ertificate of Death</i>	ntal Hygien	
Xu.	****		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medic		John A. Williams		Month D 29	2010 3:45 A ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
	3.	M.	Heartland Health Care Center			P.G.
8	Funeral		5. Social Security Number 6. Sex 7. Age (<i>In yrs. last birthda</i> 578-16-6668 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. last birthda</i> 7. Age (<i>In yrs. </i>	Months Days Hours Min.	. Date of Birth (Month, Day, Yea.	
ŷ.	Director		Usual Residence of Decedent		3-27-192	22
	yland		10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
	e Ma	ctor	D.C. Was	hington		1 ☐ Yes 2 X No
	72 hours after death with the Maryland netural', or iteme 23a or 28a-1 ehow littal Examiner must be motified at	by Funeral Director	10e. Street and Number 2240 13th St. N.E.	10f. Zip Code 20018	10g. C	Citizen of What Country? U.S.A.
	-me	ıner	11. Marital Status 1 Never Married 2 Marned 12. Was Decedent Ever in U.S. Armed Forces? 1943 – 112 Yes 2 No. 194	 Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Rie 	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte	y Fu	1 Never Married 2 Married 12 Yes 2 No! 19 19 19 19 19 19 19 19 19 19 19 19 19	1 ☐ Yes 2 ☒ No Specify:		Specify: Black
21215-0036	2 hour	edt	15 Decedent's Education 16a, De	ecedent's Usual Occupation	16b.	Kind of Business/Industry
215	within 72 ene. than "ne	plet	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of working e. DO NOT use retired)	7	Government
21	filed wit Hygiene other tha	Completed	10	Clerk		
Maryland	should be filed within and Mental Hygiene. marked other than "matic event, the Mental than than than the Mental than the Menta	To Be	17. Father's Name (First, Middle, Last) James Williams	18. Mother's Name (I Marie W	First, Middle, Maide Villiams	an Sumame)
	nd 2 salith ar		19a. Informant's Name/Relationship (Type, Print) Maurice Williams (Son) 19b. Ma	ailing Address (Street and Number or Rural R 0 13th St. N.E. W	Route Number, City lash, D.	r or Town, State, Zip Code) C • 20018
Baltimore,	Page nent o ant: If ary or		Ouantic	sposition (Name of Cem • 2-4-2) co NaT, 1	~ 4 ^	Location - City or Town, State antico VA.
Balt	permit. Depertrimports any inju		21. Signature of Funeral Service Licensee Frames B. Hunt	22. Name and Address of Facility Hun 908 Kennedy St. I	nt Funer N.W. Was	ral Home sh, D.C. 20011
	/hysician /Medical Examiner	Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	polic Encephale	pathy	Interval Between Onset and Death
68760,	aath certificate be executed attending physicien and for use as the burial-transit	edical Exa	resulting in death) Last Due to (or as a consequence of):	Prostatic Ca.	ranom	12
P.O. Box 68	the Hospital or Attending Physician: The law requires that the death certific in 24 hours after death. The Funeral Director: After this certificate has been signed by the attending pluthe Funeral Director: After this certificate as been signed by the attending pluthety filled in by the funeral director, page 2 should be detached for use as included.	Physician/Med		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
	uires that the de signed by the a Id be detached t	þ	Part II. Dther significant conditions contributing to death but not resulting in the Congostive Hours for Four Congostive		23e. Did tobacco	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
of Vital Records,	he law requir e has been si ige 2 should i	Completed	Connary Artery Disease	r	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
ta	iician: Th certificate rector, pag	e C	25. Was case referred to medical	26. Place of Death (1 Yes 2 21	No 1 Yes 2 No
<u>></u>	ysici is cer direci	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	Othor		6 ☐Other (Specify)
0	ding Phys h. After this funeral di		27. Mannerof Death 1 1 Natural 5 □ Pending (Month, Day Year) Injury 1 Pending (Month, Day Year) Injury		d. Describe how in	jury occurred
Division	eath. or: Al	Certification:	2 Accident investigation	M 1 Yes 2 No		
Σ̈́	i or Attendi after death. Director: A	ıtif	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28	If. Location (Street: City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Ce	29a. Certifier (Check only (Ch	eath occurred at the time, date and place, and rinvestigation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as stated. Indiplace, and due to the cause(s)
	thin 2 the implet	Med	and manner stated. 29b. Signatur # and tiffe of certifier	29c. License number	29d. E	Date signed (Month, Day, Year)
	- 3 - 8	1000	MA MD	4786		179/2010
R	5		30. Name and settings of person who completed cause of death (Item 23a) (Ty			70000
					100	20826
	Sta Registr		FEB 0 3 2010 Annual St. Registrate Stignate			

Division of Vital Records, P.O. Box 68760,

within 2

State Registrar

31. Date filed (Month, Day, Year) JAN 2 8 2010

29b. Signature and title of certifier

30. Name and address of nerson

1924her

completed cause of death (Item 23a) (Type, Print)

Greene

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			partment of Health and I Pertificate of Death		giene Reg. No. 2010	04804
Physic /Medi		Decedent's Name (First, Middle, Last) DARLA SMALLWOOD WRAN		2. Date of Dea Month Januar	Day Year	3. Time of Death 3:30am M
Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	
and "		4223 Talmadge Circle	Suitland	_	Prince Geo	
Funeral Director		5. Social Security Number 577-80-4854 6. Sex 1 M 2 X F 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Day Jan 18,	th ly, Year) 9. Birth Cou	place (State or Foreign intry) OH
ryland show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
e Ma 8a-f s	Director	MD Prince Georges Suitla				1 ☐ Yes 2 █ No
vith th	D.	10e. Street and Number	10f. Zip Code		10g. Citizen of What Cou	intry?
eath v	Funeral	4223 Talmadge Circle 11 Marital Status 12. Was Decedent Ever in U.S. 13	20746 3. Was Decedent of Hispanic Origin? (Sp	acify Vos or No	USA - 14. Race - Amer	ican Indian
Baltimore , Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modeal Evantina miss be notified at any injury or other traumatic.	by Fun	11. Marital Status 1. Was Decedent Ever in U.S. Armed Forces? 1. Never Married 2. Married 1. Yes 2. No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
5-0036 72 hours aft natural", or	ted	15. Decedent's Education 16a. De	cedent's Usual Occupation		16b. Kind of Business/Ir	
215 215 thin 7	Completed	(Specify only highest grade completed) (Gi	ve kind of work done during most of work DO NOT use retired)	king		
21 ed wil ygien ygien yer th	ပ်	4+ Sch	eduler		Federal Gov	vernment
Maryland d 2 should be file th and Mental Hy 7 Is marked othe traumatic event	Be	17. Father's Name (First, Middle, Last)		,	Maiden Surname)	
ryla	은	Buddy E. Smallwood, Sr.	Joyce E			
Mal d 2 st th an th an traur			iling Address (Street and Number or Ru 3 Talmadge Circle		er, City or Town, State, Zi and,Md。 201	
re, Heal Heal tem 2				Date	20c. Location - City or T	
mo Pages ent of nt: If i		124-Buriai 2 Li Cremation 3 Li Removal from State	i i	-2010	Suitland, N	M)
Baltimore, permit. Pages 1 ar Department of Hee Important: If item any injury or othe once.	1	21. Signature of Toperal Service Licensee	22. Name and Address of Facility Marshall's Funeral			ш.
→ ₽0 = % 0		Victorine, c. Woode	4308 Suitland Rd.	_Suitla:	nd,MD. 20746	Approximate
Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Breast Cancer	enter the mode of dying, such as cardiac	or respiratory ar		Interval Between Onset and Death 2 years
/Medical Examiner	ı	resulting in death) Due to (or as a consequence of):				
ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Disease or Injury				
58 / 50, ficate be executed physician and s the burial-transit		that initiated events c. Due to (or as a consequence of):				
58 / 60 ficate be physiciar s the buri	edical	d				
certific	/Mec	IF FEMALE:				
atter for u	Physician/Me		B ☐ Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
that the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
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VITAI iclan: T certificat ector, pa	a l	25. Was case referred to medical	26. Place of Dea	i □Yes		2 X No
OT VITA Physician: rthis certific ral director, I	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	Other:		dence 6 ☐ Other (Spec	ify)
_ 50 0 0	tion: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day, Year) Injury In	of 28c. Injury at		now injury occurred	
DIVISION I or Attending after death. I Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (5 City or Tow	Street and Number or Ru vn, State)	ral Route Number,
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	edical C	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, de (Check only one) 1 ☑ Medical Examiner: On the basis of examination and/or and manner stated.				
To the within To the complete complete the c	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month	, Day, Year)
		Daluhum	18948		Jan. 25, 20	10
15		30. Name and address of person who completed cause of death (item 23a) (Typ				
		Imad A. Tabbara, M.D. 2150 Penn Ave.	NW #1-100 Washir	ngton, D	C 20037	
Sta Regist		31. Date filed (Month, Day, Year) JAN 2 8 2010 Lever A. Aarch				

DHMH 17 Rev 1/2001

Physician Medica Examine **Funeral** Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit Division of Vital Records, P.O. Box 68760

	4	For State	State	of Maryland		artmen rtificate			and M	ental Hy	•	20	10	01.6	205
Physiciar	,	Registrar 1. Decedent's Name (First, Midd	le, Last)		06/	incare	01 2	Catri		2. Date of De			Year	3. Time of I	Death
Medica	al .	4a. Facility Name (if not institutio		rie Starr Za	is, Jr.	4h Cihr	Tourn or	Location of		FEBRUA	\neg			14:4	1 M
Examine	•	WMHS - REGIONAL				CUMB	ERLA	ND				c. County ALLEG			
uneral irector	- 1	5. Social Security Number 217-60-1156	6. Sex 1 X M 2 □ F	7. Age (In yrs. Ia 55		If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Ma	th a <i>y, Year)</i> ay 21,	1954	9. Birthp Count	west Vir	Foreign ginia
f show	ior	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							11	0d. Inside City	
or 28a- e notifie	Director	Maryland 10e. Street and Number	Allegany			10f. Zip	Code	Lona	coning	3	10g. C	Citizen of V	Vhat Coun	1 X Yes	2 ∐ No
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o min	ক্র	11. Marital Status 1 Never Married 2 M Ma	Armed Fouried 1 Yes	2 X No /e		Was Deced If Yes, spec 1 ☐ Yes	ify Cuba	n, Mexican,	in? (Spec Puerto F	ify Yes or No- lican, etc.)	No- 14. Race - American Black, White, etc. Specify:			etc,	
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27 is mar r traums		19a. Informant's Name/Relation:	ship <i>(Type, Print)</i> ean Zais - Wif	·e	19b. Maili	-				Route Numbered SW, L				ode) ind, 2153	9
or of the your office of the your of the		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other	n 3 ☐ Removal from	20b. PI	ace of Dispo emetery, crei		ther plac	e)		ate /2010	20c.		City or To	wn, State	and
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To the Funeral Director. After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	ğ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		eath 3 Ectopic pregnancy						23d. Date of delivery Month Day			əar		
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After this c	၉	1 ☐ Yes 2 ☐ Too 27. Manner of Death Hatural 5 ☐ Pend	28a. Date	♣patient 2 ☐ I of injury th, Day, Year)	ER/Outpatie 28b. Time o injury	2	8c. Injury work	4 <u> </u>	2	ne 5 Resi 8d. Describe					
Director: /	Certificate	3 Suicide 6 Could	mined 28e. Place	of Injury - At hor ing, etc. (Specify)		M eet, factory	_	Yes 2 🗌 I	_	8f. Location (er or Rural	Route Numbe	er,
Funeral leted filled	Medical	(Check 2 Medical	g Physician: To the b Examiner: On the ba	sis of examination	and/or inves	tigation, in	ny opinic	n, death occ	curred at t	he time, date	and plac	e, and due	e to the cau	se(s) and man	nner stated.
To the		29h. Signature and title of certific			^		. License	number 5406	The second second		29d. D	ate signed	(Month, E		.010
	0	30. Name and address of persor LAMM, WILLIAM	who completed caus	se of death (Item	23a) (Type, F	Print) BROOK	ROA	D, CU	MBER	LAND ,			•		
State Registra	-	31. Date filed (Month, Day, Year) FEB - 5	32/F	Registrar's Signati	ure			LURRO		11					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

State Registrar 29b. Signature and title of certifier

SHAHRYAR DAVARI, 1. Date filed (Month, Day, Year) 10110 MOLECULAR DRIVE, #206, ROCKVILLE, MD 20850 MD Time A pares

and manner stated.

36. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

58597

29d. Date signed (Month, Day, Year)

2010

FEB. 4,

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, G900, 2/22/2010, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Joyce Peach Anderson February 2010 5:06a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 219-66-3187 54 Director March 1955 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show Department of Heatth and Mental Hygiene. Important: "or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "hadical Examinar must be notified an once. MD Carrol1 Eldersburg 1 ☐ Yes 2 No Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 1108 Courtland Drive 21784 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) pathology lab processing supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Peach Trula V. Holland ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William J. Anderson (spouse) 1108 Courtland Dr., Eldersburg, MD 21784 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 2-24-10 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Parge Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Gustro intestin /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit and The law requires that the death certificate be exe Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Oh 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Oronan has autopsy performe certificate 2 ZNo 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

#30

State Registrar Risa Kramer Carroltown Medical Ctr.

31. Date filed (Month, Day, Year)

FEB 22 2010

Security 32. Registrar's Signature

S. Sparker

S. Sp

30. Name and press of person who completed cause of death (Item 23a) (Type, Print)

1380 Progress Way Ste. 112 Eldersburg, MD 21754

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0542 A M 2019 Margaret Mary Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Battimore Panklin Savare Pola . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 M Months Hours 03/30/192 Mary Land Director 213-12-0284 Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d Inside City Limits 10a State hours after death with the Maryland Examiner must be notified at Director Maryland Baltimore Essex 1 Yes 2 X No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral items 23a 920 Martin Road 21221 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. ò 1 Never Married 2 Married ☐ Yes 2XX No Completed by Maryland 21215-0036 1 Yes XX No Specify: If Yes Give "natural", 3 Widowed 4 □ Divorced White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or extending and Mental F is marked o 2 John Lewis Catherine Stuehler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Butta (son) 6902 Circle Road, Baltimore, Maryland 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gard 02/25/2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.

Bruzdzinski Funeral Home, P.A.

1.07 013 Factorn Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARROVTOMIO disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Syndrom To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24-parts after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 □**V**10 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

State

30. Name and address of person who completed c

31. Date filed (Month, Day, Year)

FEB 22 2010

BUHA

Square DRIVE Baltimore, MD 2123

ase of death (Item 23a) (Type, Print)

32. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No LU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Fe bruary 750 Burrel1 Michael 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death etimore NA land Gienera (77 pital Date of Birth Month, Day, Birthplace (State or Foreign Country)
 MD 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Hours Months 1**X** XM 2 □ F Days 40 216-86-5148 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County XYes 2 No MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2511 Eutaw Place Apt.#205 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. African 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: American 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) self-employed Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bernard Goode, Sr. Gertrude Burrell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iris D. Burrell-Wife 3403 Alto Road Baltimore, Maryland 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State King Mem. Pk.Cem. 02-23-10 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Stage Due to (or as a con-uence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No 24a. Was an autopsy performed? Yes 2 DNo 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation

P.O. Box 68760 Division of Vital Records,

Examiner led by the attending physician and detached for use as the burial-tran icate has been significate has been significated by page 2 should by certificate

Physician

Examiner

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

2 Accident

3 Suicide

29a, Certifier

4 🗌 Homicide

29b. Signature and title of certifier

6 ☐ Could not be

Funeral

Director

show

ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Evanting must be notified at

Department of Health and Mental Hygiene. Important; If item 27 is marked other than "any injury or other traumatic event, Inc. Maonce.

Physician /Medical

1 and 2 should be f Health and Mental

Pages 1

Baltimore, Maryland 21215-0036

/Medical

law requires that the death certificate be execute To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

> State Registrar

MD

and manner stated.

29c. License number

1 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #4b Per Phy G900 2/22/2010 JH. &17&19a State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Za/L 050 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Baltimore Randallstown TOWEST. 1 Year If Under 24 Hrs. 8.
Days Hours Min. If I Ir Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) 1 M 2 □ F Months Yrs. **Director** 0101967 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If the Medical Examination. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □Yes 2 🕱 No inde Director MOCK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3135 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 📆 No Specify. δ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) C YHC 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Milton Williams ဂ္ 19a. Informant's ame/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barnes MD THO HATTINGTHE 2135 Cedar Barn 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oalaolaoro LANSdowNE, MARYIAND 21. Signature of Funeral Service License 22. Name and Address of Facility Troc Control Control FH 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on inch line. Approximate Interval Between Onset and Death ardiac or respiratory arrest Immediate Cause (Final Physician MC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown page 2 should Completed peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 | No 1 ☐ Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 6 Other (Specify filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accident 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar' State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 18, 2010 Edward Joseph Bayer 3:30 P. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore Age (In yrs. last birthday) Social Security Numbe Funeral If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Months Days Hours. December 29" Mary Pand **Director** 218-26-3505 1930 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. Count should re filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Timonium 1 🗆 Yes 2 🔀 No 10f. Zip Code 10g. Citizen of What Country? Funeral 2300 Dulaney Valley Road 21093 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status er than "natural", or iter the Medical Examiner 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Yes 2 XNo If Yes, Give 1 XXNever Married 2 Married White 1 ☐ Yes 2 X No Specify. 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Roman Catholic Priest 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, 5Gollege (1-4 or 5+) Elementary/Seconday (0-12) Clergy Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hazel Kane 2 Joseph Bayer 19a. Informant's Name/Relationship (Type, Print) ss (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Lane Sheboygan Wisconsin 53081 9b. Mailing Address *(Street* 1616 Kaat Lane Kim Werla/Niece per it. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Hydes Maryland St. John's Long Green Feb. 22,2010 21. Signature of Funeral Service Licensee rec'hame and Address af Facility Egonard J. Ruck Inc 5305 Harford Road Baltimore Maryland 23a. Part 1. Enter the disease, or complications that wed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HEAD AND NECK CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Be Completed by Physician/Medical Examiner if any, leading to immediate Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deatle Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and j 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP 2300 DULANEY VALLEY RD. JACKIE JONES TIMONIUM, MD 21093 FEB 2 2 2010 32. Registrar's Signatur State

DHMH 17 Rev 7/2009

Registrar

p.m.

FEBRUARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O 20 10 13:20 DWar Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maryland Medical Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 🛛 M 2 🗆 F Months Hours Director Usual Residence of Decedent 3a or 28a-f show be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 □ No 10e. Street and Numbe 10g. Citizen of What Country? Funeral "natural", or items 23 Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 19a. Informant's Name/Relationship (Type, Print) CORNIS Important; If item 27 any injury or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Department of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. 21. Signature (F) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ntractable Physician Seizures disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner rebrovascular Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 4 ☐ Pregnant a 9 ☐ Unknown Pregnant at time of death 2 No is certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Lunknown 24b. Were autopsy findings available prior to completion of cause of death? alcohol abuse 24a, Was an autopsy After this certificate 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifie 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The deficiency in Section 19 in Novelege, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only on 29b. Signa and title of certific 29d. Date signed (Month, Day, Year) D0065118 13 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month,

DHMH 17 Rev 7/2009

Rhodes, MD

ancie C.

22 S. Greene Street

Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician Day 6:30 PM /Medical ebruary 2010 4a. Facility Name (If not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Kandalstown amoin 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Hours Min. 216-82-5604 Months Days HO Yrs. Director 19ry Como Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examiner must be notified another. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 No Honore 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 33 amoine Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) sable 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last, æ ပ 19a. Informant's Name/Relationship (Type. Print) Number, City or Town, State, Zip Code) 21133 19b. Mailing Address (Street and Number or Rural Route Randallstown moine 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of meral Service Lic towell MD 2125 Heights alto 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each life. Do not enter the mode of dying, such as cardia; or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence as the burial-tran P.O. Box 68760, physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year ned by the a 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 2 No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 25 No 1∏Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signat License number 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Vickie **Bailey** 2 Date of Death Physician/ Month 5:00 PM FBRUAR Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death SECOURS BALTI MORE 8. Date of Birth (Month, Day, Ye 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** O,1956N.Carolina 1 M 2 F Months Hours 218-62-5480 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural". or items 93a or 98a.f ehm 10b. County 10c. City, Town or Location Baltimore Completed by Funeral Director 10d. Inside City Limits N/A1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4100 WoodRidge Road USA 21229 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Specify: lack 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Syrname)
Dorothy M. Blackwell ೭ Thomas Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 3906 Norfolk Avenue Baltimore, Mary land21216 Margo Wright/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Lansdowne, Maryland Zion Cemetery 2/20/10 Mt. Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home Baltimore, MD 21215 Reisterstown Rd 23a. Pp. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ STAGE disease or condition resulting in death) LIVER Medical Examiner LITE if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 autopsy performed? Yes 2 No death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director; After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 ... Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 000303 55 BON SECOURS State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20i State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Mary Alice Barbour 02 35 20 2010 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b City, Town, or Location of Death 4c. County of Death 520 8. Date of Birth **Funeral** 7. Age (In yrs, last birthday) If Under 24 Hrs. 1 □ M 2√2 F Months Hours Min. 216-52-0598 09/23/4950 59 Director Yrs. Usual Residence of Decedent MRN-216 or 28a-f show notified at 10b. County 10c. City, Town or Location Director Mary.land n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 3308 North Hilton Street #301 3321216 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, injury or other traumatic event, the Medical Examiner MARY Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. ò þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: Black "natural" 3 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Environmental Technician Johns Hopkins other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ unknown permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Dow/ Friend 6516 Eberle Drive #101 Baltimore, MD 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore. MD Burial 2 Cremation 3 Removal from State Zion Cometery Memorial Park 2/27/10 Lansdowne, Signature of Funeral Service Licen 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, MD21215 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Septicaemia disease or condition Medical resulting in death) Examiner rinasi Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Month 1 ☐ Yes ≥ ✓ 9 ☐ Unknown has been signed by the le 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Completed by ebro Vas culas 1 Yes No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate ha performed? Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number All hate M.D. RES- DOO 02 09 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABHIJEET GHATOL 5601 Luch Raven Bird. Baltimore MD

3. Time of Death

9. Birthplace (State or Foreign Country)
NC

10d. Inside City Limits

Approximate Interval Between Onset and Death

Dav

1 ☐ Yes 2 ☐ No

Year

1

Yes 2 □ No

06', 21 AM

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** 10 atou zertrude :00 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5008
5. Social Security Number Himore Year I if Under 24 Hrs. Wathe Hve more 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday)
Yrs. 6. Sex **Funeral** Months Days Hours 1 M 2 M Director 920 irginia Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Item Medical Examination within a standard or the traumatic event. 10c. City, Town or Location **Funeral Director** 1 ☐ es 2 ☐ No timore 10f. Zip Code **2**1 2 10g. Citizen of What Country? Walther Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ To If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify. Be Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) econdary (0-12) College (1-4or 5+) 17 Father's ame (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Buto. Baltimore. ☑ Burial 2 ☐ Cremation 3 Removal from State 5 ☐Other (Specify) 21. Synature of Funeral Service E 401560 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician uars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undership Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Ebenczer Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? HOUSE 1 🗶 Natural 5 ☐ Pending investigation 1 ☐ Yes To the Hospital or Attend within 24 hours after death To the Funeral Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Nurse Practitioner 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completes cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) FEB 2 2 201 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician ARNOLD FEBRUARY 15 2010 03:20P M BARR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEVINDALE BALTIMORE N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex Funeral Days 1 X M 2 □ F 81 Yrs. 11/01/1928 MD 141-22-8932 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 X No notified Director MD BALTIMORE PIKESVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be 10 POMONA SOUTH. 21208 Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify 3 Nidowed 4 Divorced natural", WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) nt of Health and Mental Hygiene.
If item 27 Is marked other than or other traumatic event, the Me College (1-4or 5+) SALESMAN WHOLESALE MEAT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BENJAMIN BARR ပ HELEN WEINER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENI TABOR / DAUGHTER 848 S. BOND STREET, BALTIMORE, MD 21231 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition 20c. Location - City or Town, State Department of h Important: If ite any Injury or ot once, 1 ABurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CONG. 02/19/2010 | WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on use of line. Immediate Cause (Final disease or condition resulting in death) **Physician** CJ 771 /Medical Due to (or âs a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed inding physician and use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9∏Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 2 7 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown te has Leen si age 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 ☐ No 4 Aursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 🗌 Yes 2 Accident 2 🗆 No 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

n 24 hours after death.

The Funeral Director: Af olderely filled in by the fun Hospital within 24

State

UJUV 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only

and manner stated.

30. Note and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

34 W Betweene

MARCARET DAYMBACH Baltimore. Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Please			k indelible ink Department of I		•	•	
		For State	State of M	-	Certificate of		, ,	2010	01.818
		Registrar 1. Decedent's Name (First, Middle, La	est)		- Invalor		Reg. No 2. Date of Death	2010	3. Time of Death
Physicia /Medica	al	Margaret M. Ba			Ab City Town	or Location of Death	ebruary 1	y Year 15 2010 c. County of Dea	0 5:20 PM
Examine	er	LORIEN E	301 AI	R	Be. City, lowing	I AIR	1	HARR	ENRI
Funeral		5. Social Security Number 6. S		ge (In yrs. last birt	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year Dec. 22, 1	9. Bir	thplace (State or Foreign
Director		214-14-3349	1□M 2x F	93	Yrs.	Tiodis Iviii.	Dec. 22, 1	916 Mar	yland
and and	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Mary a-f sh	햦	Maryland Harfor	rđ.	Fore	est Hill				1 □Yes 2₩No
or 28	Director	10e. Street and Number		1	10f. Zip Code		10g. C	itizen of What Co	ountry?
ath w		1835 Beth Bridg	T		2105			ed Stat	
items	Funeral	11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent Armed Forces?)	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe van, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
S s s s	৯	3 Widowed 4 □ Divorced	1 □Yes 2 □ If Yes, Give Year or Dates:	C °	1 □Yes 2000No	Specify:		Specify: Wh	ite
natura Meal B	Completed	15. Decedent's E	ducation ade completed)	16a.	Decedent's Usual Occu	pation	16b. F	Kind of Business	/Industry
han "	d E	Elementary/Secondary (0-12)	College (1-4or s	5+)	(Give kind of work done life. DO NOT use retire	ed)			
Hygie ther t		17. Father's Name (First, Middle, Last	·)		Homemaker —	18 Mother's Name	(First, Middle, Maider	wn Home	
ld be lental ked o	To Be	Edgar P. Feige	,			Ruth McG			
should be and Mental s marked o	-	19a. Informant's Name/Relationship	(Type. Print)	19b.	Mailing Address (Street			or Town, State,	Zip Code)
and 2 ealth a		Margaret R. Pott	er/Daughte	er 1	835 Beth Br	idge Circl	e Forest H	Hill, MD	21050
permitting of the property of the permitted within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Mones.		20a. Method of Disposition 1 □Burial 2 □ Cremation 3 □	Removal from State	20b. Place of cemeter	Disposition (Name of y, crematory or other pla	reb. Da	19, 20c. L	ocation - City or	Town, State
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Depa Impo any Ir		21. Signatur Juneral Service Licel	nsee		22. Name and Addre Evans Fune: 3 Newport		& Cremati	on Serv	içe-BelAir
	\dashv	23a. Part 1. Enter the disease, or comshock, or heart failure. List on	p cations that cause	d the death. Dor	IS Newport I	Drive Foreing, such as cardiac or	st Hill, No respiratory arrest,	lary Land	Approximate
Physician	1	Immediate Cause (Final disease or condition	/		A, END				Interval Between Onset and Death
/Medical		resulting in death)		a consequence of		SIMOL			
Examiner	_	Sequentially list conditions, if any leading to immediate	b		40				
nsit .	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to for as	a consequence o	et):				
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icate be physicis the bur	<u>ea</u>		⊾d						
The law requires that the death certifical ate has been signed by the attending phy age 2 should be detached for use as the	Physician/Medi	IF FEMALE:	000 K						
eath certific attending p	Sian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death	3 ☐ Ectopic pregnand			23d. Date of de Month	livery Day Year
that the dended by the a	Jysic	1 □ Yes 2 027No 9 □ Unknown	9 Unknown	at time of octain	3 Gottlei (specify)				
s that	ya 된	Part II. Other significant conditions	contributing to death b	out not resulting in	the underlying cause given	ven in Part I.	23e. Did tobacco	use contribute to	o the cause of death?
w requires to been significant should be	<u> </u>	COPD, HYPE	RTENSION	٧,			1 ☐ Yes 2	P No 3□P	robably 4 🗆 Unknown
e faw in has b	Completed	CARDIAC ARRH	ITHMIA				24a. Was an autopsy	prior to	utopsy findings available completion of cause of
Ician: The certificate hisector, page							performed? 1 □ Yes 2 😾 N	death? o 1 ☐ Yes	s 2 □No
rsicia s certi	2 Re	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2□ER/Ou	tpatient 3 DOA Oth	26. Place of Death	(Check only one) ne 5 ☐ Residence	€ □Other (Car	
iding Physician: th. After this certifica funeral director, p	0 ::	27. Manner of Death	28a. Date of Inju	ury 28b. T	ime of 28c. Injury Wor	ry at 2	8d. Describe how inju		scuy)
eath. or: Al	catic	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	n	9,700.	· ·]Yes 2□No			
or At after d Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of inj	ury - At home, far c. <i>(Sp</i> ec <i>ify)</i>	m, street, factory, office	2	8f. Location (Street a City or Town, Stat		ural Route Number,
		29a. Certifier 12 CertifyIng Pt	nysician: To the best	of my knowledge	, death occurred at the t	ime, date and place. a	and due to the cause	s) and manner a	s stated.
n 24 t n 24 t n E Fun	Medical	(Check only 2 Medical Examone)	miner: On the basis of and manner st	of examination an	d/or investigation, in my	opinion, death occurre	ed at the time, date ar	nd place, and du	e to the cause(s)
To the vithing complete the com	Ž	29b. Signature and title of certifier	7		29c. Licens	se number		ate signed (Mon	
		Mulhap				344	0:	2/16/2	C10
		30. Name and address of person who					20101-5		/n 7 0
State		SURESH DHANJ 31. Date filed (Month, Day, Year) FEB 22 201	22. Registr	ar's Signature	UNION HER	HAVRE	DE GKHCK	MAd	10 /8
Registra	•	FEB 22 201	O Sentina	B. A	harles	_			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bankir Month .2 Day Year an 2010 0043 16 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death UNIVERSITE OF MANTIME MEDICA CGATER Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 Ohio (Month, Day, 1 🔀 M 2 🗆 F Months Days Hours Min. 269-42-4929 62 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yes 2 I No Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 159 Mt. Royal Avenue 21001 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1966—
If Yes, Give 1970 Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: 3 Divorced white 1970 Specify: Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Civil Service</u> US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Edward Banker Anna Ruth Wolford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Fay Walker Banker (Wife)</u> Mt. Royal Ave., Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 反 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Harford Memorial Gardens 2/23/10 Aberdeen, Maryland Signature of Funeral Service Licenses Tarring-Cargo Funeral Home, P.A. Aberdeen. Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between nediate Cause (Final

Physician/ Medical **Examiner**

AMOD

31. Date filed (Month, Day, Year)

Physician/

Medical

10a. State

Director

Funeral

Completed by

Be

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Examiner

Funeral

Director

show

iral", or items 23a or 28a-f sho Examiner must be notified at

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"natural",

permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I.

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the burial-tran physician attending pl the 8 within 24 hours after death.

To the Funeral Director; Affer this certificate has been signed by 'completed filled in by the funeral director, page 2 should be detacl

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	disease or condition resulting in death)	a. Due to (or as a consequence of):	17 Fibrosis		-	Oriset and Death
aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to or as a consequence of				
dical Exa	that initiated events resulting in death) Last	Due to (or as a consequence of):				
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		ctopic pregnancy hther (specify)		23d. Date of deliv	ery Day Year
eted by P	Part II. Other significant conditions o	contributing to death but not resulting in the und	erlying cause given in Part I.		use contribute to t	he cause of death?
				24a. Was an autopsy performed?	prior to co death?	psy findings available impletion of cause of 2 No
Be	25. Was case referred to medical examiner?		26. Place of Death (Check	(only one)		
2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other: 4 Nursing Ho	me 5 Residence	6 ☐ Other (Specifi	·)
Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be			28d. Describe how inju		
	4 Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)		28f. Location (Street a City or Town, Stat	'e)	
Medical	(Check 2 ☐ Medical Exami only one) 3 ☐ Certifying Nurs	sician: To the best of my knowledge, death occ iner: On the basis of examination and/or investiga se Practioner: To the best of my knowledge, dea	ition, in my opinion, death occurred at	the time, date and place	e, and due to the ca	use(s) and manner stated
	29b. Signature and title of certifier		29c. License number	20d D	ate signed (Month	Day Yearl

CA-A81360

University of Martino Madic Cartax 22 South Gregorst Bullinger Md 21201

29d. Date signed (Month, Day, Year) 02/18/2010

DHMH 17 Rev 7/2009

State

Registrar

ack

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TINdulkar

2 2 2010

			1 - For State Registrar	State of Maryla		ent of Health and ate of Death		ı.No.	04020
Р	Physici	an	1. Decedent's Name (First, Middle,	Last)	Pi-no		2. Date of Death Month	Day Year	3. Time of Death
	/Medic xamin		4a. Facility Name (If not institution,	give street and number)	(LY / / (4). (City, Town, or Location of De	eath TONUTIN	4c. County of Death	10-00 ft "
Fu	neral		5. Social Security Number		s. last birthday) If Un	nder 1 Year If Under 24 H	Irs. 8. Date of Birth (Month, Day, Y	9. Birti	hplace (State or Foreign
	Director		Usual Residence of Decedent	1 M 2 MF 8	Yrs.	ths Days Hours M	FEB 2,	1929 MAR	YLAND
Marylan	s show	ō	10a. State 10b. County	10c. C	City, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 🖪 No
ith the	or 28a	Direct	10e. Street and Number	000	10f	Zip Code	10g	. Citizen of What Co	untry?
death v	ms 236	Funeral Director	922 TYV	12. Was Decedent Ever in Armed Forces?	U.S. 13. Was D	ecedent of Hispanic Origin? specify Cyban, Mexican, Pu	(Specify Yes or No-	14. Race - Amer	rican Indian,
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	d other then naturel, or tems 23e of 28er's now event, it e Medical Examinet must be notified at	b	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced			s 2 No Specify:	ieno nican, etc.)	Specify:), etc.
215-0036 thin 72 hours at e.	ledical i	Completed	15. Decedent's (Specify only highest	grade completed)	16a. Decedent's l (Give kind o	Jsual Occupation f work done during most of the Tuse retired)	working 16	b. Kind of Business/I	ndustry
d 212 filed with Hygiene.	of, If e	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	cert	V SECRETA	RY A	COOUNTI	NG
d be	and Mental	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) RUBY HALL						
and 2 should balth and Men			19a. Informant's Name/Relationshi	(Type, Print) - DALVSHTER	19b. Mailing Add	ress (Street and Number or	Rural Route Number, C	ity or Town, State, Z	(ip Code)
Pages 1 at Near of Hea	or other		20a. Method of Disposition 1 🗆 Burial 2 🗷 Cremation 3		Place of Disposition cemetery, crematory	Name of or other place) Scl.	Date 20	ic. Location - City or 1	Fown, State
Baltimore, permit. Pages 1 a Department of Hex	y injury or		`4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Li	100	FINS FUN PKA 22. Nam	and Address of Facility	800 HAKHOKO K	MONU PAKKUU	LE MU 2123
n && 1	8 8		23a, Part1, Ententine disease, or co	omplications that caused the de.	ath Do not enter the	FUNERAL CHAP	PCL-I CREMA	TION SERV	Approximate
	nysician		23a. Part1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition	ity one cause on each line.	ctoth	rive.	nac or respiratory arrest	,	Interval Between Onset and Death
/Me Exan	dical niner		resulting in death)	Due to (or as a conse	equence of):	mestica			
pet	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
e execu	urial-tra		that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):				
. BOX 08/00, death certificate be executed	ng physician and as the burial-transit	ledicai		d.					
DOX leath cert	for use	cian/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3 □Ectopi	c pregnancy (specify)		23d. Date of delin	very Day Year
hat the c	Jetachec	Physician/	1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant condition	9□ Unknown			22a Did tabas		the serves of death?
The faw requires that the	en signe ould be c	Ω	- arm significant condition		sadding in the underlyii	ig cause given in Part i.		cco use contribute to	obably 4 Hhknown
he faw re	ge 2 sho	Completed					24a. Was an autopsy performe	prior to c	topsy findings available completion of cause of
Or VICAL Physicien: T	actor, pa	Be Co	25. Was case referred to medical examiner?	Turner I			1 Yes 2 Death Check onlone		2 No
g Physic	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	n: To	1 Yes 7 No	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	☐ ER/Outpatient 3☐ 28b. Time of Injury	DOA Other: 4 Norsing 28c. Injury at Work?	Home 5 Residence 28d. Describe how		ify)
Vitending death.		Certification:	Natural 5 Pending Pe	ion	М	1 ☐ Yes 2 ☐ No	28f Location (Stree	at and Number or Rui	ral Route Number
oitel or Jura after	lled in b		4 Homicide building, etc. (Specify) City or Town, State)						
To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After	pletely fi	edicai	29a. Certifier (Check only and manner as stated. (Check only and manner as stated. (Check only one) (Check one) (Check only one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check on						
With	Com	Σ	29b. Signature and title of certifier	M. I	<i>O</i> .	29c. License number	29d.	Date signed (Month	Day, Year)
			30. Nam address of person of	o completed cause of death (Ite	em 23a) (Type, Print)	Juio 0	Finte 20 8	Truron 1	40 21201
	Stat	· e	31. Daye filed (Month, Day, Year)	22. Registrar's Sign	nature			10-4	10 21659
R) DHMH 17 F	e gistra Rev 1/20		FED 2 2 2U	10 Sentin &	1. parks				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nonth 2 Physician/ 5:58PM RITICE Medical 010 4a. Facility Name (if not institution, give street and number) 4c. County of Death BALTIMORE **Examiner** 4b. City, Town, or Location of Death BALTIMORE NORTH OAKS 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days Hours Min. 09/925/1927 Country) Director 057-22-2638 82 Yrs NY Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f shov Examiner must be notified at State 10b. Count 10c. City, Town or Location 10d, Inside City Limits Director **BALT IMORE** BALTIMORE 1 🗆 Yes 2 💢 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 725 MT. WILSON LANE, APT. 802 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married 1 Yes 2 No 2 should be filed within 72 hours aft tht and Mental Hygiene. 27 Is marked other than "natural", traumatic event, the Medical Exar 1 ☐ Yes 2 🔀 No Specify: WHITE Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **BOOKKEEPER** AMERNIC CO. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ RAPPOPORT JOSEPH 3 1 SCHATZ CLARA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra HOWARD COHEN/HUSBAND 725 MT. WILSON LANE, APT. 802 BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD MOSES MONTEFIORE CEM 102/19/2010 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD, PIKESVILLE, . INC. MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final disease or condition resulting in death) Onset and Death Chronic Physician/ KIONEL Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death 1 ☐ Yes ∠∕o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred **Hospital or Attending** 1 Natural iniury 5 Pending work?
1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29c. License number 29d. Date signed (Month, Day, Year) CUN, Sanp R125808 18

\0 √ State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar

DHMH 17 Rev 7/2009

Balto

Villamusts, CRNP 3835 Smoth the Stc 203

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Re

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04822 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 2039 PM DILEGGE AROLINA FEBRUARY 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE JOHNE HORKINS BATVIEW MEDICAL CENTER Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min (Month, Day, Year) Director 214-82-9568 9 <u>Italy</u> 10 - 1925Usual Residence of Decedent show 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City. Town or Location 10d. Inside City Limits Director or 28a-f st notified MD 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 21206 4808 Pleasant View Avenue U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 4th Own Home Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Giuseppe Canestraro Annunziata DiCocco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna DiLegge - Daughter Pleasant View Avenue Balto.Md. 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Page 1 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 M Other (Specify) Entomb Holy Redeemer 2-24-10 Baltimore, Maryland Most permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph N. Zannino Jr. 1 Balto. Md.21224 Conkling Street 23a. Part 1. Caster the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Pinal Onset and Death Ph_sician/ LEFT FEMORAL NECL disease or condition 10 HOUR Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINE nding physician ause as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? be detached for Month Day Year Pregnant at time of death the signed by Ather significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed pertonsion certificate 2 🗌 No 1 Yes Was c s referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending atural within 24 hours after death. To the Funeral Director: A 10:45 AM 1 ☐ Yes 2 ☑ No Accident Investigation 12010 FELL DOWN STAIRS 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number of City or Town State) determined HOME AT

P.O. Box 68760 Division of Vital Records, Hospital or Attending Physician:

> State Registrar

completed

Medical

29a. Certifier

(Check

only one) 29b. Signature and title of certifie

mon 31. Date filed (Month Da

4940 EASTERN AVENUE 32. Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 2

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

BALTIMONE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** therine February 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days Maryland 6-1-1921 Director 220-05-9174 88 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 □ No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ō must be U.S.A. Linwood Avenue 21224 items 23a 626 S. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates; 14. Race - American Indian, 11, Marital Status Black White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify Specify: White þ 3 ₩ Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Injury or other traumatic event, the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) other than Food Preparer Haussners 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of Dolce Augustino Concetta Antonio 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) _daughter Department of Health ar Important: If item 27 is any Injury or other trau once. Nancy M. Poremski 5502 Benton Heights Ave. Balto. Md.21206 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holy Redeemer Cem 2-22-10 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph N. Zannino 263 S. Conkling Steet Balto. Md. Zannino Jr. F.H. lto. Md. 21224 co 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Dué to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death
9 Unknown Month Day Year 5 Other (specify) 1 Yes 2 No the ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 TYes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 26. Place of Death Check onl one 25. Was case referred to medical Be Hospital: 1 Inpatient Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence 1 Yes 2 No 2 ER/Outpatient 3 DOA 6 Other (Specify) မှ 28a. Date of Injury

Abouth Day Year) al Director: After this ed in by the funeral d 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day 1 Natural 2 Accident Injury 5 Pending investigation 1 Yes 2 No after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined completely filled in by 4 Homicide 24 hours a Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the the Hospital 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-COU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ghh 600 North Wolfe St, Baltimore, MD, 21287 Kevin 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician =Rom ORSE 2010 /Medical 4a, Facility Name (It not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 13 ALTIMORE ND Juder 1 Year | If Under 21212 If Under 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 1□M 2□F Months Days Hours Director 220-36-0348 69 01/21/1941 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I've Medical Evarence in ust be nothing an once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Yes 2□No Director MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Cooperative Drive 21212 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No <u>ک</u> Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cab Driver Yellow Cab 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) James Harper Dorsey Alice Smith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronette Dorsey-Daughter 923 Evesham Ave Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 02.18.2010 Baltimore, MD 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 21. Signature of uneral Service Licensee apris 23a. Pari 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** astoma multiorme yenres /Medical Due to (or as a consequence of): Examiner avcold Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and physician ar Due to (or as a consequence of): Completed by Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a ☐Yes 2☐No 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🐧 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 Д No 24a. Was an certificate has lirector, page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation ours after death. Accident 1 ☐ Yes 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

To the Hospital or Attending Physiclan; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Baltimore

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 14, 11:50 PM 2010 Wilbur T. Driver Medical 4a. Facility Name (if not institution, give street and nul Examiner 4b. City, of Death 4c. County of Death Town, or Local Baltimore Washington 5 2 mne 8. Date of Birth 3/30/1930 9. Birthplace (State or Foreign Funeral If Under 1 Year If Under 24 Hrs. Country) Maryland 1 X M 2 - F Months Days Hours Min Director 217-26-1598 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Anne Arundel Glen Burnie Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 U.S.A. 7211 Crown Road . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 3 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Black Completed 3 Widowed 4 Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) W. T. Cowan Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Helen Driver Wilbur O. Driver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7211 Crown Road Glen Burnie, Maryland 21060 Doris Driver 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place injury or 1 X Burial 2 Cremation 3 Removal from State 02/27/10 Baltimore, Maryland 4 Donation 5 Other (Specify) Mt. Calvary Cemetery 21. Signature of Funeral Service 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 2 23a. Part 1. Enter the it sease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failers. List only one cause on each line. Interval Between Immediate Cause (Final O east. Physician/ Onset and Death disease or condition Medical resulting in death) Due to or as a consequent Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit that initiated events Due to (or als a resulting in death) Last consequence of Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year ☐ Yes 2 ☐ No ed by the a 9 Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à page 2 should be Division of Vital Records, 2 No Completed 3 Probably 4 Unknown 1 Yes has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe this certificate the funeral director, Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: npatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 5 Pending s after death. 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) thin 24 hours a Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one d title of certif 29b. Signature a 29d. Date signed (Month, Day, Year) 20 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #20b are of Maryland /Department of Health and Mental Hygiene

1 - For State Registrar 04826 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 16 2010 **Physician** 6:59P M Julia Lydia Devilbiss /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll arroll Hospice Dove House Westminster 8. Date of Birth (Month, Day, Year) February 2,1916 Birthplace (State or Foreign Country)
 PA If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 🗓 F Months Days Hours Director 94 183-07-4475 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, II is inadical Evantmer must be notified at 10a, State Yos 2 □ No Director MD Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 208 St. Mark Way 21158 Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 If Yes, Give Year or Dates 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien. Important: If Item 27 is marked other tha any injury or other traumatic... Teller/bookkeeper Bank 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Boyer William H. Saltzgaver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 526 Baltimore Blvd. Westminster, MD 21157 Donald Hull/P.R altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 02/24/2010 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Uniontown, MD 4 ☐ Donation 5 ☐ Other (Specify) Uniontown Meth. Cem. 2/26/2010 22. Name and Address of Facility Hartzler Funeral Home of garine 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2/16/10 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): sician and burial-transit certificate be executed Cause (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 No P.O. ed by the a 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1 ☐Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dit 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 V atural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 2/17/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Physician Year 2:30A Leslie LeRoy Earl 2010 18 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Franklin Square Hospital Center Rosedale Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours Min 218-26-5649 80^{Yrs.} **Director** 09/01/1929 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c City Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1548 Dornton Avenue by Funeral 21220 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2XXVo Specify. Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, Insulonce. Manager Telephone Company 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) William John Earl ္ဝ Ada Elizabeth Knight 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Earl (Wife) 1548 Dornton Avenue, Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc. 02/18/2010 | Baltimore, Maryland 21. Signature of Funeral Service III enses 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PESPICATOR (JISTRES) 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner ardiomyo path Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transit PSis and Due to (or as a consequence of) ed by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760, Perforation Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) ☐Yes 2 MNo 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Anemia Coronary artery disease 1 ∏Yes 2 ∏No 3 Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as 2 autopsy Clostridium difficil perform certificate 2 No 2 1 No 1 ☐ Yes 1 ☐ Yes r this certific ral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation s after death.

Il Director: A

od in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) the and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES00000

State Registrar

31. Date filed (Month, Day, Year) FEB 22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Awat Singh, MD 9000 Franklin Square Dr. Baltimore, MD 21237 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04828 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Joseph Fletcher Ellis Medical 2010 8 · 30P 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sandtown Winchester Nursing Home Baltimore N/A Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🔀 M 2 🗆 F Months Days Hours (Month, Day, Year, 94 **Director** 215-18-5727 July 915Maryland Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director N/ABaltimore 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 'n 10g. Citizen of What Country? ral", or items 23a o Examiner must be Page 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a ury or other traumatic event, the Medical Examiner must b Funeral 2412 Calverton Heights Avenue 21216 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 **N**0 Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes Give Specify: Black Completed 3 ¥ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Repairman Self employed 8th grade 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Ellis Rachel Howe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 Regena Vaughan/ Daughter 7118 N.Alter Street Baltimore, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot Burial 2 Cremation 3 Removal from State Western Star Cemete ₹ 20/201 (Catonsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licens Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore. 23a. Part. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DIVOUTO Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; T e law equires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death cale has been signed by the a page 2 should be detached to 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed this certifica e has keen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 10 Hospital 2 🗹 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After Natural injury 5 Pending Accident 1 Tes 2 🗌 No Investigation within 24 hours after death To the Funeral Director; 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 16000 0267 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RALTO MD 21211 RUD

State Registrar

DHMH 17 Rev 7/2009

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 234 am **Physician** 14,2010 IE FARRAR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner AMORE Jary/ana Genera 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** Year) 241-32-4758 1 M 2 M Months Days Hours NORTH CAROLINA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a fluidiest Evartine must be notified at any injury or other traumatic event, it as fluidiest Evartine must be notified at any once. 1 Yes 2 □ No Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number U.S.A. STREET 21217 Funeral MOSHER 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify: <u>ک</u> Specify: BLACK 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER LOUSE WIFE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MC CIEESE JAMES SKINNER ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32/2/7 19a. Informant's Name/Relationship (Type. Print) GRAND. Street, BALTIMORE, MOSHER MARVIAND ALYSON HAYDEL DAUGHTER 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 20/2010 HERTFORD, NORTH 4 ☐ Donation 5 ☐ Other (Specify) THE DERRICK C. JONES FIH, P.A 22. Name and Address of Facility 21. Signature of Funeral Service Nicenses PARK Hats. AVE., BALTIMORE, MARY lAND App oximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 1515 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Garakenous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Dagulo burial-trar Due to (or as a consequence Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe o 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Ves 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records. Physician: The ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director; After t

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Maryland 21215-0036

Baltimore,

attending the has certificate this After 1

11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

2010

D. 90 Maryland General Hos

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAHULKUMAR SINGH

GULAB

State Registrar

completely

the within 7 Medical

DHMH 17 Bev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LOIS E. FORSYTH FEBRUAR Pay 19. 7:14PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F Days Hours Min. (Month, Day, Year 9/11/1930) Director 213-26-3740 MARYLAND 79 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE 1 Yes 2X No PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1717 NORTHVIEW ROAD 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify: WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) BILLING LAFARGE 12TH GRADE Be age 1 and 2 should be filed int of Health and Mental Het III item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 CHARLES L. SOHL EVELYN M. LIVINGSTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1717 NORTHVIEW ROAD GEORGE FORSYTH/HUSBAND BALTIMORE, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 permit. Page 1 Department of Important: If it any injury or o 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place)
MORELAND MEM. PARK 2/23/2010 4 ☐ Donation 5 ☐ Other (Specify) HILLENDALE, MD 21. Signatury of Funeral Service Vicensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, MO1139 Yau 8521 LOCH RAVEN BLVD. TOWOSN, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, ACUTE MYOCARDIAL INFARCTION Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if the cause Enter Underlying Cause (Disease or linjury Examiner Dusi to for as a considuence of the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year the 9 Unknow signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 : autopsy perforr 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 1 XInpatient 2 ER/Outpatient 3 DOA Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) d Director: After the din by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 Tes 2 🗌 No Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hou. the Funeral Directory filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

DHMH 17 Rev 7/2009

Registral P. P. V.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601

32. Pegistrar's Signature

DBWE63

DRIVE TOWSON,

29d. Date signed (Month, Day, Year)

MARYLAND

10-01325 Leroy A Frazier, Jr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

eroy A Frazier	, Jr	S 1- For State Registrar	tate of Maryla	_		nt of Heal e <i>of Deat</i>		Mental H		20 l	0 04831
Physici Medical Exam		Decedent's Name (First, Middle Leroy Alexand		r, Jr		-			2. Date of Dea Month February	th	3. Time of Death 1723 hrs
		4a. Facility Name (if not instituti Harbor Hospital Cent	on, give street and nun			4b. City, 1 Baltin		cation of Death		4c. County of n/a	Death
Funeral Director		5. Social Security Number 220 –80 –1 91 3	6. Sex	7. Age (In yrs.		ay) If Und Month Yrs.		If Under 24Hrs Hours Min.	_	th (MM/DD/YYYY)	Birthplace (State or Foreign Country)MD
any		Usual Residence of Decedent 10a. State 10b. County			, Town or	l			00/12/	1900 [10d. Inside City Limits
faryland 28a-f show 1.at once.	Director	MD 10e. Street and Number	n/a			Bal 10f. Zip	timore	9	11	0g. Citizen of Wha	1 Yes 2 No
with the Maryland is 23a or 28a-f she e notified at once		2932 Carver 1	Road 12. Was Dece	dent Ever in U	J.S. T1:		1225	nic Origin? (Sc	pecify Yes or No	USA 14. Race	American Indian, Black,
0036 within 72 hours after death with the Maryland giene. her than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 N 3 Widowed 4 Di	Armed For 1 Yes	ces? 2 X No		If Yes, specif	fy Cuban, Mo	exican, Puerto	Rican, etc.)	etc. Lack	
5-0036 led within 72 hours af Hygiene. other than "natural the Medical Examin	Completed I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Truck Driver							16b. Kind of Busi	ŕ	
Hygeled	Be	17. Father's Name (First, Middle Leroy Alexand	der Frazier	r, Sr			18.N Rc	chelle	Hodges	Maiden Surname)	
MD 2. nd 2 should alth and Man 27 is man an	To	19a. Informant's Name/Relations Felisha Fraz			822	25 Mill:	field	Ct Mil	lersvil	nber, City or Town, le, MD 21	108
ore, slar of Hee If ite		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other S	,	n State	crematory	isposition (Nan or other place) ount Cre			Date 4.2010	20c. Location - C	city or Town, State
Baltimo permit. Page Department of Important: injury or oth		21. Signature of Funeral Property	ensee			²² Name and Chatma 5240 R	Address of I n-Harr eister	raility Fun cstown	eral Ho Rd. Bal	me timore, N	∕ID 21215
Physician /Medical Examiner		23s Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	nsive	cardi				r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a c								
cuted nd transit	I Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	onsequence o	of):						
60, ate be executed hysician and e burial - transit	Medical	☐ MAPENDED IF FEMALE:	23c. If yes, ou	23a,27		nE, g90	0 2/23	3/10 TT	& PII	23d. Date of de	elivery
Box 68760, he death certificate be executed yr the attending physician and hed for use as the burial - transit	ysician/Me	23b. Was decedent pregnant in the past 12 months?	ne 1 Live bin	th nt at time of de	2	Fetal death Other (Spec		Ectopic pregnal	ncy	Month	Day Year
ires that the disagned by the	d by Phy	Part II. Other significant condit	ions contributing to o	death but not r	esulting in	the underlying	cause giver	n in Part I.			te to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	Completed						_		24a. Was a autop: perfor	sy prid med? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No
Vital Rec hysician: The this certificate	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: CT	patient 2	ER/Outpa		OA Othe	Death (Check of er;4 Nursing	nly one) g Home 5	Residence 6	Other:
ion of vending Ph.	ation: T	27. Manner of Death 1 X Natural 5 Pend 2 Accident Inve	28a. Date of (Month, Date) ding stigation	Injury (ay,Year)	28b. Time	e of Injury 2	8c. Injury at	_	28d. Describe h	ow injury occurred	
Division ipital or Attend ners after death filled in by the	Certification:	3 Suicide 6 Coul 4 Homicide		of Injury - At h	ome, farm,	street, factory,	office buildi	ing, etc.	28f. Location (S or Town, St		or Rural Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire	Medical	one) 2 Medical Exa	nysician: To the best on the best on the basis of and manner sta	examination a		stigation, in my	opinion, dea	ath occurred at			
	Σ	29b. Signature and title of certific	or D, ND			29c	O.C.M.E			29d. Date signed February 14,	(Month, Day, Year) 2010
		30. Name and address of person Ling Li, MD Assista	who completed cause nt Medical Exam		,	treet, Baltin	nore, MD	21201			
St	ate	31. Date filed (Month, Day, Year)		strar's Signatu	iren	barker					

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month **FELDMAN** SHIRLEY 1:45 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinou Hospital of Bouti more Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 NV **Funeral** 1 □ M 2 🗓 F Hours 0670371919 **Director** 90 Yrs NY 124-16-4636 Usual Residence of Decedent show 10a. State 10b. County : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 725 MT WILSON LANE, #703 21208 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: WHITE 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) SOCIAL WORKER CHILDRENS GUILD Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ IRA HAAS DORETTA BERNHARDT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 SUZANNE ROSENTHAL 15 OLD ELM COURT, LUTHERVILLE, MD 21093 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once. / DAUGHTER ent 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of ARE TNGTON AND PROPERTY CHIZUK AMUNO 20c. Location - City or Town, State 4 Donation 5 Other (Specify) 02/19/2010 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Le May 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Bonsey and Death Immediate Cause (Final Phelimouria Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) signed by the attending physician and deed be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 1 Yes 2 1 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cancer 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No After this certificate Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending iniury Accident
Suicide Investigation after death completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) elimen 0068650 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Tazeen Rehman, Sinai Hospital of Baltimore 2401 W Belvedere Ave Baltimae 101 MO 21215 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10-01316 Valerie Ferrell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Valerie Ferrell		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2010 0483
Physiciar Medical Examin	1/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year February 13, 2010 3. Time of Death 1315 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1308 Slater Road 4c. County of Death Baltimore
Funeral Director	- 1	5. Social Security Number 1 M 2 F 7. Age (In yrs. last birthday) 1 M 2 F 7. Age (In yrs. last birthday) 1 M 2 F 7. Age (In yrs. last birthday) 1 Months Days Hours Min. Dec. 4, 1980 Country) 1 Dec. 4, 1980 Country) 1 Dec. 4, 1980 Country)
36 in 72 hours afte han "natural". itcal Examine	Completed by Funeral Director	Usual Residence of Decedent 10a. State
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other injury or other traumatic event, the Med	10 Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensie 22. Name and Address of Facility 22. Name and Address of Facility 22. Name and Address of Facility 23. Name and Address of Facility 24. Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25. Place of Disposition (Name of cemetery, Crematory or other place) 27. Name and Address of Facility 28. Name and Address of Facility 27. Name and Address of Facility 28. Purvious Chapter - Parkuille
Physician /Medical Examiner	4	23a. Part I. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Approximate Interval Between Onset and Death Due to (or as a consequence of): Due to (or as a consequence of):
box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit	ealcal	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d. AMENDED AMENDED AMENDED 23a, 27, per ME g901 3/19/10 TT IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown AMENDED 23a, 27, per ME g901 3/19/10 TT 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown
F Vital Records, P.O. Physician: The law requires that the rth is certificate has been signed by ral director, page 2 should be detach	to be completed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1
Division of To the Hospital or Attending Phe within 24 hours after death To the Funeral Director: After the completely filled in by the funeral Confifencial Confidencial Conf	Certification	1 X Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Stat		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature
Registra		FEB 2.2 2010 Parage A Special

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

Month **Physician** LEONA DERVIN e6, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** DENEKA (In yrs. last birthday) \$5 Yrs. Birthplace (State or Foreign Country) **Funeral** <u>219-12-7752</u> Usual Residence of Decedent **Director** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "motion Evand net must be notified at 1 XYes 2 No Director Columbia 10f. Zip Code Houser 10e. Street and Number 10g. Citizen of What Country? 9060 End 21046 Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1- Wes 2 □ No Army If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No 9 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Transportation 19 Drixer Departit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, Important: If item 27 is marked any Injury or other to once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Leonard Garner / Father Irene 19b. Mailing Address (Street and Number or Rural Route Nu , City or Town, State, Zip Code) 21046

1060 Gracious End Court + Caumbre, MD

ce of Disposition (Name of Local)

Date JNK 20c. Location - City or Town, State 19a. Informant's Name/Relationship (Type. Print) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date JNK 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) renatoru 21. Signature of Funeral Service Licenses 22. Name and Address Lility 1232 Midveilley Approximate Interval Between Onset and Death 23a. Cart I onter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imme in te Cause (Final dis se or condition resulting in death) TOVANCES **Physician** /Medical (or as a consequence of): Examiner ennunca Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). law requires that the death certificate be executed burial-transi en enta and Due to (or as a consequence of) attending physician for use as the burial 01 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) P.O. 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Hospital or Attending 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SVITE 31. Date filed (Month, Day, Year) 32. State Registrar Barks

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death __ Month Physician 0700 A M Kenneth Ray Ghee el)ulas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ST- AGNES HOSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Year) Months Days Hours Min 1 ☑ M 2 ☐ F 212-88-1622 Maryland Director 40 969 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits ?? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at Baltimore N/A Yes 2□No Director Marvland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21230 2208 Sidney Avenue Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☑ Never Married 2 ☐ Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Ş Q Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Fire Dept. Mechanic 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Florence Ghee William Kirk ల 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Kevin Ghee 903 Dantrey Ct. Baltimore, MD 21215 other Department of Heal Important: If item 2 any injury or other once. altimore, 20a. Method of Disposition 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🛭 Cremation 3 ☐ Removal from State 18/ Baltimore,Maryland Greenmount Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Lice 5240 Reisterstown Rd Baltimore, MD 21215 23a, Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** TOXOPLASMOSIS Days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Years IMMUNO DEFICIENCY HUMAN if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-tran and resulting in death) Last Due to (or as a consequence of): 68760, aftending physician for use as the burial Physician/Medical IF FEMALE P.O. Box 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) ed by the a detached fi Tyes 2 No. 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2. No 2 🗆 No 1 ☐ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 2 Accident investigation 1 ☐Yes 2 ☐ No filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Malling. A MD 22257 2010 04 MALLIKA ANGITIPALLI, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 S. CATON MD-21229 ST. AGNES HOSPITAL BALTIMORE AVENUE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For 1 _ State		State of Ma	aryland /	•			Mental Hy	giene		
		_	Registrar 1. Decedent's Name (First	t Middle Las	*)		Cert	tificate of	Death ————————————————————————————————————	2. Date of De	Reg. No.	2010	04836
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	/Medic Examin		4a. Facility Name (If not in			11	1 1 0	4b. City, Town, or	r Location of Death	1 / 03	40.	County of Dea	ath /
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	Funeral		5. Social Security Number		7. Age	(In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Bir	rthplace (State or Foreign ountry)
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral S	service Licens	96 - L	MA	22.	Name and Addres		10			
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نحور			GOVY KOZK 31. Date filed (Month, Day,	Vear)	D /UTOS	H(CKC	ry Krd	Je Kel	Colun	2519	MAZ	21047
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Physician CGINA 5 56 AM 2010 /Medical SIL ANT 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMUNA 7010 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdav) Birthplace (State or Foreign **Funeral** Date of Birth Months Days Hours Min. Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: þ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation ind of Business/Industry work done during most of working
Tuse neticed) Elementary/Segondary (0-12) Be ၉ 20a. Method of Disposition Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) re of Furieral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Completed by Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed CONONARY Anteny signed by the attending physician and be detached for use as the buriat-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this nours after death.

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filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 🔲 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

State Registrar

31. Date filed

M.D

3001 South Hanover

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** RICIA 1902 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL RANDALLSTOWN RALTIMONE CENTER 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Date of Birth (Month, Day. **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F Director 212-42-1894 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examinant nest be notified at Director 1 ☐ Yes 2 XNo Baltimore MD Windsor Mill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or items 23a 2702 Helmsley Street 212/4 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married specifican-American Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☑ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. NCIA 12th Residential Counselor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Isiah Williams ပ Ella Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Tamera R. Williams-McPherson/ Daughter 8318 Liberty Rd., 2nd Floor, Woodlawn, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 2-26-2010 Woodlawn, MD 22. Name and Address of Facility Wile Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that deused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ENOTIZ CANDIOVASCULAR DISEAS E **Physician** disease or condition resulting in death) /Medical Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physlcian: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 menths?
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4 Pregnant at time of death
9 Unknown 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? cate has b autopsy performed certificate 2 No 1 □ Yes funeral director, 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 400 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death. To the Funeral Director: A 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saima Khawaja, MD 9901 Liberty Road Randallstown, MD 21133 32. Registrar Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Doris G. Hornberger 10:45 PM Feb 18 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Transitions Health Care Sykesville Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Apr 1918 Days 91 Hours Min 213-78-9739 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Funeral Director MD Carroll 1 Yes 2 No Sykesville 10e. Street and Number 397 Ronsdale Rd. 10f. Zip Code 21784 10g. Citizen of What Country? United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ permit. Page 1 and 2 should be filed within 72 hours after opearment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or 1 Never Married 2XXMarried Yes 2XXNo Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 24 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working th and Mental Hygiene. 27 is marked other than traumatic event, the Me life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12th Homemaker her home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Scheidt Edith Slonaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Tucker (Son) 397 Ronsdale Rd Sykesville, MD 21784 Department of Healt Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 2/22/2010 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 2178 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Condovasinca Disease Immediate Cause (Final enun (Physician/ heroscl disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months? Year Month Day Pregnant at time of death 1 ☐ Yes 24 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown or Attending Physician: The law requires Records, cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 1 2 🗌 No 1 🔲 Yes Division of Vital filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred **⊘** Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical LEC Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

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completed fi (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) မ a.

State Registrar MAUMUUD

Rd Westminit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February bell 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Towsor timore Social Security Number Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, If Under 1 8. Date of Birth **Funeral** Days 1 🗆 M 2 🕏 Months Min. Director Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Himore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 Funeral 3 reenn 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates Specify: Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DQ NOT use retired) th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, La 18. Mother's Name (First, Middle, Maiden Surnam ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/10 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory, or other place 20c. Location - City or Town, State Date 1 Burial 2 remation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Servi e Lice 21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or) a consequence of): Physician disease or condition resulting in death) 2004 Medical Examiner Sequentially list conditions, fan, having to improve cause. Enter Underlying Examine Due to lor as a consequence of ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 completed filled in by the funeral director, page 2? autopsy 2 🗍 No 1 Tyes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at 5 Pending 1 Yes 2 No Accident Sulcide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAN MO 6701 NOKTH DOBER 31. Date filed (Month, Day Yo

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2<u>010</u> Month Feb. Physician/ 13 8:30P.M Dorothea Hart Geraldine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 5404 Gwynndale Avenue 8. Date of Birth
(Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthdav 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√2 F Months 218-16-8895 87 **Director** Märvland Usual Residence of Decedent show or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or edical Examiner must be n Funeral 21207 USA 5404 Gwynndale Ave Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces 1 Yes 2 X No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: 3X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) London Fog Co. Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward Stamps Rosie Hazelton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 5404 Gwynndale Avenue Baltimore,Maryland Rose Edwards/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State 2/20/10 Woodlawn, Maryland Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21 Simply of Tuneral Serial Lo 22. Name and Address of FacilityChatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) a. Myocaron Due to (or as a consequence of): INFINACTION 1キノノノハ Medical Examiner ATHINOSCLUNOT morowscum Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine MISHING Due to for as a consequence of: the Hospital or Attending Physician; The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it g | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier l 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar & CAMP MERONI OCOM; LINITHOUN, NO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:45 R Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A **Baltimore** Joseph Richey Hospice, Inc. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland (Month, Day, Year) Jun 9, 1956 Months Days Hours 1 🗆 M 2 😿 F Director Yrs 53 212-10-2829 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 🗆 Yes 2 🗀 No **Baltimore** N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21230 U.S.A. 2613 South Paca Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Yes 2 No 1 Yes 2 XNo Specify: If Yes, Give Black 3 Divorced 4 Divorced Completed Maryland 21215-00 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ann Sykes James Webster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2625 Carver Road Baltimore, Maryland 21225 Nicole Hill 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State timo 1 XBurial 2 Cremation 3 Removal from State 02/25/10 Brooklyn Park, Md. 4 Donation 5 Other (Specify) Cèdar Hill Cemetery & Mausoleum Signature of Foneral Service Licen 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Esquentiany list curvitions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the funeral director, page 2 should be detached for use as the burial-transit attending physician and Due to (or as a consequence of): Physician/Medical $\mathcal{K}\mathcal{H} \wedge \mathcal{H}\mathcal{H} \qquad \mathcal{H}\mathcal{H}\mathcal{H} \wedge \mathcal{H}\mathcal{H}$ Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? ☐ Live Birth 2 ☐ Fetal deat ☐ Pregnant at time of death ☐ Unknown Month Day Year Yes 21 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by DM 2 7 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has, autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I the Hospital or Attending Physician: The 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence မ 27. Magner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending M Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) HENDRIX Physician/ 10:30 PM EBRUAR 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BON BALTIMOR Cours If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Oct 21 1 4M 2 F Maryland Director 37 218-84-0216 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County notified at Director 1 Yes 2 No Baltimore 28a-f N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò must be 23aFuneral U.S.A. 814 North Monroe Street 21217 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married ö Yes 2 X No permit, Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Black 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify Completed 3 Widowed 4 Divorced "natural" 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Greyhound Bus Company College (1-4 or 5+) Elementary/Seconday (0-12) **Badges Handler** Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental 20 Novella Hawkins David Hawkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 814 North Monroe Street Baltimore, Maryland 21217 Health tem 27 Constance Watson item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o ō cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State Lansdowne, Maryland 02/26/10 Mt. Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility reral Service Libe Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part 1. Enter the Sease, or complications that caus // the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each i.e. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To Be Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, . Were autopsy findings available prior to completion of cause of 24a. Was an cate has i page 2 s autopsy death? 2 🗌 No 1 TYes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient eral Director: After thi filled in by the funeral 28b. Time of 27. Mann Death 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) within 24 hours a To the Funeral C Descritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Descritifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Descritifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier ၉ and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Middle, Last)	00,	unca	o or bear		2. Date of Dea	Reg. No.⊆ U ith	10	3. Time of	Death
	Physicia Medic		Francis E	Earl Hoff					Month Februa	r 13	Year 2010	3:20	РМ
	Examin		4a. Facility Name (if not institution, give s	treet and number)		4b. City	, Town, or Location	on of Death		4c. Count	ty of Death		
1			Frederick Memori				Freder				reder		
H	Funeral Director		5. Social Security Number 6. Sec	GM 2□ □		Months	Days Hour	s Min.	8. Date of Birt (Month, Da)	, Year)	Coun	place (State o	r Foreign
			217-12-1225 Usual Residence of Decedent		87 Yrs.				Mar. 2,	1922	I Mar	yland	
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	th the 3a or t be n	al D	10e. Street and Number	1 5		10f. Zi	ip Code	1702		10g. Citizen of	What Cour	ntry?	
	within 72 hours after death with the Maryland gjene grent than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	6792 Sunnyb	12, Was Decedent Ever in U.	S 13	Was Doce	dent of Hispanic	1702	ocify Yes or No-		ce - Americ	on Indian	
က	er dea or ite niner	by Fi	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 No		If Yes, spe	ecify Cuban, Mexi	can, Puerto	Rican, etc.)		ack, White,		
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Baltimore, Maryland 21215-0036	should be filed on and Mental Hyor is marked oth traumatic event	P P	J. Earl Hoff						Lonie F	. Lambe	ert		
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Σ	nd 2 s ealth m 27		Judy Hoff/wife				nybrook 1	Dr.	Frede	rick, D	4ID 21	702	
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Bo	death ne atte ed for	sici	in the past 12 months? 1 Yes 2 No	4 Pregnant at time of 9 Unknown		Other (s				M	onth	Day	Year
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of	ng Ph fter th ineral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time o injury	f	28c. Injury at work?		28d. Describe h	ow injury occu	rred		
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Division of Vital Records,	or At after c Direct in by	Certificate:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special		reet, facto	ry, office		28f. Location (S City or Tow		ber or Rura	l Route Numi	ber,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlal-transit		29a, Certifier 1 Certifying Phys	ician: To the best of my know	vledge, death	occured a	at the time, date a	nd place, ar	nd due to the ca	use(s) and man	ner as state	ed.	
	in 24 h	Medical	(Check 2 L Medical Examir	ner: On the basis of examination of the best of n	on and/or inves	stigation, ir	n my opinion, deatl	h occurred a	t the time, date a	nd place, and d	lue to the ca	use(s) and ma	anner stated.
	withi To th		29b. Signature and title of certifier	29c. License number 29d. Date signed (Month,									
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_	10		30. Name and address of person who co		, , , , ,	,	210	N/±	7) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	24774			
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10-01486 Stephen Harms

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 04845 1. For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day February 18, 2010 Medical Examiner 1420 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 116 Glen Avenue Salisbury Wicomico 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Months Director 1 V M Country) [V 2___F Usual Residence of Decedent iny 10b. County 10d. Inside City Limits 1 Yes 2 No 28a-f shov "natural", or items 23a or 28a-f shor Examiner must be notified at once. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 Never Married 2 Married 2 V No Yes 3 Widowed f Yes, Give Year 1 Yes 2 V No specify: Divorced Specify: ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industr Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname Be è 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, item 27 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or 2 V Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify. 21 Signature of Funeral Service Licensee 3800 **Physician** the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and /Medical Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, permE, g901 3/2/10 TT the attending physician red for use as the burial -X UNPENDED Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Ectopic pregnancy Day Fetal death Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed by ector, page 2 should be detach Completed by 1 Yes 2 No 3 Probably 4 ✔ Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical Hospital or Attending Physician: 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene this ER/Outpatient 3 DOA 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural neral Director: / filled in by the fi Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 2 To the 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

OCME 2006

State

Assistant Medical Examiner 2. Registrar's Signature

30. Name and acdress of person who completed cause of death (Item 23a)

Pamela E. Southall, MD

February 19, 2010

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 2 2 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MSKyapaksem.D

N.S. Rajapakse, M.D.

D0057465

2835 Smith AV. 5-203, Baltimore, MD: 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10:57 AM Joseph A. Jirinec 14,2010 February 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8216 Rockdale Avenue Baltimore Windsor Mill If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign March 17, 1913 | Maryland 7. Age (In yrs. last birthday) Social Security Number 1 € M 2 🗆 F 213-03-3220 96 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 □Yes 2 No MD Baltimore Windsor Mill 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 8216 Rockdale Avenue 21244 Usa 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∏Yes 2 ☐ No If **Ye**s, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: white 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Sun Engraver 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barbara UNKNOWN Anthony Jirinec 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3027 Edgewood Avenue-Parkville, Maryland 21234 Michael Jirinec-son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1√ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Parkville, Maryland Feb. 18,2010 21. Signature of Funeral Service Licensee Evans Funeral Chapel and Cremation Service 8800 Harford Road-Parkville, Maryland 21234

231. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate 22. Name and Address of Facility I m e hate Cause (Final dine v e or condition rest ting in death) ic cardiovascu Widisease ter osdero Due to (or as a consequence of): Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 X No 24a Was an 2**V** No 1∐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

2

Funeral

Director

Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

d 2 should be filed within 73 h and Mental Hygiene. 7 Is marked other than "n.

Pages 1 and 2 should be

permit.

death with the Maryland

72 hours after

21215-0036

Maryland

Baltimore,

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burial-transit and the page 2 should

The law requires that the death certificate be executed

or Attending

Hospital

within 24

Division or Vital Records, P.O. Box 68760,

Physician/Medical Examiner þ Be Completed

Medical Certification: To

physician ò certificate has funeral director, After this 24 hours after death Funeral Director; filled in by

25. Was case referred to medical examiner'

Manner of Death

29a. Certifier (Check only one)

3 Suicide 4 Homicide

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (tern 23a) (Type, Print),

and manner stated.

31. Date filed (Month, Day, Year)

29b. Signature and title of certified

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #7 per FH,G901, 3/2/10 Tertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month FEBRUARY Physician/ 2010 12 43P GEORGE FRANKLIN KEARCHNER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Hours Country) 61 Director 219-46-048 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1-Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 681 SIVALIE 97 702 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced 4 Divorced Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9 th echanic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Franklin Kearchner Marie Agnes Bittner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) sheila Kearchner war rew Drive trederick, MDairoa Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ONK cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) xematocu 21. Signature of Pheral ervice Licensee 22. Name and Address of A cility 1233 Mi dvalles 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or ondition resulting in death) Physician/ ardiog en Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last chae Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Dav Year Pregnant at time of death tate has been signed by the a page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No 25. Was carre erred to medical within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD 69430 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 West Seventh Sma ALI Maryla Registrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2010 Neil Klingelhofer 12:45pm^M Charles Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson If Under 1 Year If Under 24 Hrs. Social Security Number , Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Min. 1 ₹ M 2 □ F Months Hours April Day Year) 1923 Director 214-36-9067 86 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director MD Baltimore Randallstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10807 Liberty Road 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 0 þ 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2v No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced Completed White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Farmer Baltimore County/Agric Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William E. Klingelhofer Blair Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) Mr. C. Neil Klingelhofer, Jr. permit. Page 1 and 2 2801 Manchester Road, Westminster, MD 21157 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Holy Family Cemetery 2/22/2010 4 ☐ Donation 5 ☐ Other (Specify) Randallstown, MD Signature of Funeral Service Licensee HÄTGHT FÜNERAL HOME & CHAPEL, PO Box 195 Sykesville, MD 217 Hardt MOO 764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician ancer. disease or condition resulting in death) 1201 Medical Due to (or as a co. sequence of) [']Examiner Sequentially list conditions, Examine if any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 No signed by the a g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autops, performed 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 S (1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Dea 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed file Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HANES M

HOW

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 281 per me,g900.02/22/2010 dnb Certificate of Death Reg. No. 04850 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 08 Physician 2010 7:20 p M John F. Kern /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 308 Washington Ave. Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1**X**7M 2□ F 58 Yrs. Director 218-56-8804 May 18, 1951 Washington DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 👿 No Funeral Director Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21286 524 Epsom Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2**X** No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Imporant: If Item 27 Is marked other that any Injury or other traumatic event, the Once. Probation Officer State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Marv Spasaro Jerome Kern 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 524 Epsom Rd. Towson, Md. 21286 Mrs. Denise L. Kern/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 Removal from State Hilltop Service Co. 2-15-10 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Namern Address Wsolf Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician YXIG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): $28\,\ell$ Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 25 No 24a Was an 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) WG Y Yes 2□ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28d. Describe how injury occurred Suicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Certification: 5 Pending investigation 1 Natural February & 2010 | (20 P M | 1X 28e. Plac. of inury - At home, farm, street, factory, office building, etc. (Specify) 1XYes 2 □ No by Hanging
28f. ocation (Str. and United Street Repairs Route Number,
City or Town, State) 308 Washington 2 Accident 6 ☐ Could not be 3 Suicide 4 ☐ Hornicide determined building e c. (Specify) - office Avenue, Towson, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

FEB 22 201

DHMH 17 Rev 1/2001

Trumbl

who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year :45 M 2010 FA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Maryland Medical Baltimore)niversity र्व If Under Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth Funeral 239-09-6190 1**X**] M 2 □ F **Director** Usual Residence of Decedent or items 23a or 28a-f shov miner must be notified at 10a. State 10b. County 10c. City. Town or Location with the Maryland 10d. Inside City Limits Director timore 1 Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral 2801 ala16 sea errace within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) should be filed within 72 hours are want and Montal Hygiene
7 is man ed other than "natural", or item 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 ☑ Widowed 4 ☐ Divorced permit. Page 1 and 2 should • filed within 72 hour Department of Health and Mr ntal Hygiene Important: If item 27 is man ed other then "naturany Injury or other traumati event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working inc. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) ndav (0-12) pervisor Be ٥ et and Number or Rural Route Number, City or Town, State, Zip Code) and Baltimore, ace of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nemoria . Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ brain barachnoi hemmorha disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner da down Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Due to (or as a consequence of): tate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 2 🗆 No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 🗀 Pending tall down stairs 21:00M 1 🗌 Yes 2 🔀 No 112/2010 Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
MY DESTRE PENDELT ON HOUSE 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2311 ROSALYN AVE BALTIMORE, MD 2 determined BALTIMORE, MD 2/2/6 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Cartifying Nurse Practioner: To the best of my knowledge deeth on 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0065118 2/13/2010 Stance C. Rhodes, MD 223. Greene St. Baltimore, MD 31. Date filed (Month, Day, Year) egistrar's Signati State Registrar

DIVISION OF VITAL DECORAS, P.O. DOX 00/00,	1
To the Hospital or Attending Physician: The law requires that the death certificate be executed	/I Ex
within 24 nouts aret death. To the Funeral Director: Affer this certificate has been signed by the affending physician and	Vie Can

		Please Type or Print in State of Maryla	nd / Depa		alth and Me	ental Hygie	ene	
Physiciai /Medica		1. Decedent's Name (First, Middle, Last) Thomas J. Kozlouski		-		Date of Death Month Pebruary	Day Yes 18 201	3. Time of beath 2 0 10:16 A M
Examine	er	4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Cen 5. Social Security Number 6. Sex 7. Age (In yr.	ter s. last birthday)	4b. City, Town, or Lo Towson If Under 1 Year If		B. Date of Birth (Month, Day, Y	4c. County of De Baltimo	eath
Director		214-36-9159	O Yrs.			(Month, Day, Y May 18, 19		Country) ennsylvania 10d. Inside City Limits
vith the Mary	Funeral Director	MD Baltimore	Baltimo	10f. Zip Code		10g	. Citizen of What	1 □Yes 2 X No
	by Funeral	2620 Burridge Road 11. Marital Status 1 Never Married 2 Married If Yes, Give		Vas Decedent of Hispa f Yes, specify Cuban, N		ify Yes or No- can, etc.)	Black, Wi	merican Indian, nite, etc. White
ind 21215-00; be filed within 72 hours tal Hygiene. d other than "natural" event, the Mudical Ex	Completed b	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced	dent's Usual Occupatio kind of work done durin DO NOT use retired) inist	n	1/1	b. Kind of Busines	ss/industry
The state of the s	Io Be Co	17. Father's Name (First, Middle, Last) Thomas John Kozlouski	- Paci	18	. Mother's Name (i		,	-
Mar Mar nd 2 sho alth and 27 is m		19a. Informant's Name/Relationship (Type. Print) Patricia Kozlouski/Wife 20a. Method of Disposition 20b.		=	Number or Rural I	ore, MD 2		· · · · · · · · · · · · · · · · · · ·
altim mit. Pag partment portant: y injury oce.		1 □ Burial 2 🖫 Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Fyneral Service Licensee	vans Fun Bel Air	eral (habel)	Feb. 21 2010	, I	Porest Hill	L, Maryland
M & B & B & B		23a. Part 1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	<u>)</u>	ooo nactord R	oau, Parki	ице, мо	21234	Approximate Interval Between Onset and Death
8760, at the between the between the burial-transit the burial-transit tircal Examiner		Sequentially list conditions, if any, reading to mini-eulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conse	rquence of):	tery d	isene	/	U	oys.
P.O. Box 6876 hat the death certificate be of by the attending physici letached for use as the but havsician/Medical	iysicializmet	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	tal death 3 □	Ectopic pregnancy Other (specify)			23d. Date of o	lelivery Day Year
cords, P.O. w requires that the de been signed by the should be detached	2	Part II. Other significant conditions contributing to death but not re	sulting in the un	derlying cause given ir	n Part I.	1 ☐ Yes	2/No 3□	to the cause of death? Probably 4 Unknown
Vital Recorc islan: The law requirecting the law requirector, page 2 should Be Completed		25. Was case referred to medical	+0)	26	. Place of Death (prior t	
Division of Vital Records, P.O. Box 687 to the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medical		examiner? 1	28b. Time of Injury	B DOA Other: 28c. Injury at Work? M 1 Yes	4 ☐ Nursing Home 28d 2 ☐ No	5 ☐ Residence	injury occurred	pecify) Rural Route Number,
To the Hospital within 24 hours To the Funeral completely filled	icalical -	29a. Certifier (Check only one) 29 Medical Examiner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the time, cestigation, in my opinion	on, death occurred	at the time, date	se(s) and manner and place, and d	ue to the cause(s)
		30. Name and address of person who completed cause of death (Ite	. М. m 23a) (Туре, Р	00	1442	Te RI	houng	18,2010
State Registrar		Louis E. Granzi MP 6 31. Date filed (Month, Day, Year) FEB 22 2010		chi-les J	アル	70 IW	212	04
DHMH 17 Rev 1/2001	1	The second of th	ORIG	INIAI				· · · · · · · · · · · · · · · · · · ·

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🥎 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Feb^{Day}, 2010^{Year} 70 Esther Laws Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore **Baltimore** St. Elizabeth Rehab & Nursing Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Oct 10, 1925 1 □ M 2 🙀 F So. Carolina Director 220-24-1969 Usual Residence of Decedent show 10d. Inside City Limits 10a, State 10b. County with the Maryland Ħ 10c. City, Town or Location Director or 28a-f sh notified a 1 Yes 2 □ No N/A **Batlimore** Maryland 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 2542 West Pratt Street 21223 U.S.A Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Black Specify Completed 3 Widowed 4 Divorced Year or Dates and Mental Hygiene.
I is marked other than "natur raumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carrie Laws Earl Laws Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sł Department of Health ar Important: If item 27 is any injury or other trau 2226 Linden Avenue Baltimore, Maryland 21217 Eugene Laws 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 02/19/10 Brooklyn Park, Md. 4 Donation 5 Other (Specify) Cedar Hill Cemetery & Mausoleum 21. Signatura Tuneral Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P 300 Eutaw Place Baltimore, Md 212 23a. Part 1. Eyer the disease, or complications that caused the death shock, if heart failure. List only one cause on each line. to not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate curse. Enter thoselying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi 170 Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No ó Month Dav Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown 1 L Yes 2.g Unknown be detached the o signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9. þ hypothyroidism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Records, Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed PVO certificate 1 Yes 2 No 25. Was case referred to medica examiner? Division of Vital funeral director, 26. Place of Death (Check only one) Be Other: 4 Mursing Home 5 A Residence 6 A Other (Specify) Hospital: 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred After (Month, Day, Year) injury 1 Natural 5 Pending 2 🗆 No Accident Investigation after death Director: / filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Decrifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 29b. Signature and title of certifie 0 29c. License number 29d. Date signed (Month, Day, Year) CRIP R111615 2112110 Berson 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3320

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day Robert VALTER Feb. 18 2010 7:15a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4136 Hanover Pike Carroll Manchester If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth NOV • 27,1943 9. Birthplace (State or Foreign Days Penn. 66 220-42-9134 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Maryland Carroll 1 ☐ Yes 27 No Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4136 Hanover Pike 21102 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: White Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Material Supplies Superv Black & Decker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Hunt Leister Ruth Ellene Sterner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria D. Leister - wife 4136 Hanover Pike, Manchester, MD. 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) F & b 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State John Luther Miller Cem. 4 Donation 5 Other (Specify) Westminster, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eckhardt Funeral Chapel P.A 3296 Charmil Dr. Manchester, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENCEMALODA 4 months disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 ☐ Unknown 25 27

the death certificate be executed P.O. Box 68760,

Physician

Examiner

Funeral

Director

show

ns 23a or 28a-f shorenst be notified at

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 ury or other traumatic event, the Medical Examinar must

permit. Pages 1 Department of H Important: If ite any Injury or ot

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altimore, Maryland 21215-0036

Director

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Division of Vital Records, or Attending Physician:

					_				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
. Was case refer examiner?	red to medical						26. Place of De	eath (Check only one)		
1 Yes 2	No	Hospital	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
. Mann Deat 1 Accident	5 ☐ Pending investigation		Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c.	. Injury at Work? 1 ☐ Yes 2 ☐ No	_	d. Describe how injury	occurred	
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		1						1			
a. Certifier	1 Certifying Ph	ysícian:	To the best of my kno	owledge, death	occurr	ed at	the time, date and pla	ce. an	d due to the cause(s)	and manner as stated.	

To the Hospital or Attendi Swithin 24 hours after death. To the Funeral Director: A

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

D31660

62mon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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12010

State Registrar 31. Date filed (Month, Day, Year) FEB 2 2 2010

Minutes

32. Registrar's Signature

GALVIN IN MA

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1	For 1 - State Registrar	sse Type or Pri State of M		Depar		Health :	and Ment	al Hyg		010	01.055
		Decedent's Name (First, Midd)	le, Last)					2. Da	ate of Deat	h		3. Time of Death
Physicia /Medio		Elaine L.	Lentz						onth FURT 4	Day 18	2010	5:15PM
Examin		4a. Facility Name (If not institution				4b. City, Town, o		of Death		4c. Cour	nty of Deal	
r		Genesis Multin 5. Social Security Number	nedical Centa	ge (In yrs. last birt	KRd.	TOWSON If Under 1 Year			1204	_	Himo.	thplace (State or Foreign
Funeral Director		216–14–7021 Usual Residence of Decedent	1 M & F 86		Yrs.	Months Days	Hours	Min. Augt	ate of Birth Nonth, Day, IST 20	, 1923	Mary	ountry)
yland yland		10a. State 10b. County	,	10c. City, Town	or Loca	ition						10d. Inside City Limits
e Mar 3a-f sl	Director	Maryland Baltim	ore	Timoni	ium							1 □Yes 2 □No
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72 h	letec	15. Deceder (Specify only highe	nt's Education est grade completed)	16a.	(Give ki	nt's Usual Occu nd of work done	during mos	st of working		16b. Kind of	Business	/Industry
withir iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		o NOT use retire naker	<i>(u)</i>			Own	Home	
be filed within 72 hours after death with the Maryland ntal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examination must be notified.	Be C	17. Father's Name (First, Middle,	Last)		TIONIC	, control	18. Moth	er's Name <i>(Firs</i>	t, Middle, I			-
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2 sho n and is ma		19a. Informant's Name/Relations Valentine William L			_			er or Rural Rou t #204 Ti		-		
1 and 1 Health em 27 Hear tr		20a. Method of Disposition	CITEZ OI TRUSE			tion (Name of	JC WUI	Date				Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantice must be notified at once.		Burial 2 Cremation 4 Donation 5 Other		cemeter	ry, crema	itory or other pla ey Mem Gro		Feb 22,20		「imoniur	-	
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permi Depa Impo any is		Mennes 154	WNON KEN	aku)			5500 Yo	ork Road E	Baltimo	ore, Man		
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To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical		ng Physician: Te the bes I Examiner: On the basis and manner s	of examination an								
Fo the vithin of the complex	Mec	29b. Signature and title of certific				29c. Licen	se number		2	29d. Date sig	ned (Mon	th, Day, Year)
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Q.		30. Name and address of person Michelle Ka		70 - 1	(Type, P	rint)	04004			210/		
D	•	31. Date filed (Month, Day, Year) 32. Regis	rar's Signature			21204					
Sta Registr		FEB 2 2 201	O Beneral	A Asa	a Plane	,						
4	201		100.00	20. 102. CA	10000					<u> </u>		

DHMH 17 Rev 1/2001

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			For State Registrar	State of Mar	ryland /		artmer <i>rtificat</i>			Mental I	Hygieni Reg. No	$\angle U \mid U$	04856		
	Physici		1. Decedent's Name (First, Middle, Las	. 6111	Kas.	zu	k			2. Date of Month	Death Da	13 20	3. Time of Death		
ÿ	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,		Location of Dea	th	P	. County of De			
	Funeral Director		Good Samarita 5. Social Security Number 6. S 196-18-1154		(In yrs. last) If Unde Months	r 1 Year	Itimore If Under 24 Hrs Hours Min	8. Date of	Day, Year)	irthplace (State or Foreign Country) ennsylvania		
	yland sow		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, To	own or L	ocation						10d. Inside City Limits		
	Ba-1 st	Director	MD Bal	timore		Bal	timor	9					1 □ Yes 2 No		
	with th		10e. Street and Number				10f. Zip	Code				itizen of What	Country?		
	deeth	Funeral	8901 Jasper Lane	12. Was Decedent Ev	ver in U.S.	13.	Was Dece	2123 dent of Hi	54 spanic Origin? (5 n, Mexican, Pue	Specify Yes or	No-	14. Race - Ar	nerican Indian,		
Maryland 21215-0036	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-1 show aumatic event, the Medical Examinar must be incitified at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:)		1 ☐ Yes		n, Mexican, Puei Specify:	to Hican, etc.)	Black, Wi	white		
15-0	n 72 h "netu	letec	15. Decedent's Ec (Specify only highest gra		16	(Give	edent's Usu kind of wo DO NOT u	ork done o	furing most of we	orking		Kind of Busines			
212	giene.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)) F		ce Gua		,			timore Police	County		
and	a la p ≥	Be	17. Father's Name (First, Middle, Last)						18. Mother's Na			n Sumame)			
3	should be nd Mental marked c	ဥ	Stephen Schuster 19a. Informant's Name/Relationship (1)		1	9b. Mail	ing Address	s (Street a	Anna Ku			or Town, State	. Zip Code)		
	and 2 : lealth ar m 27 Is her trau		Anna Bean-daughte						Avenue-B						
ore	of H		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	Removal from State	20b. Place ceme	tery, cre	matory or o	other plac	e)	Date		ocation - City			
Baltimore,	Pa ment ury		4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		Evans and C	rem	ation-	-Bela nd Addres	is of Facility	.17,201	0 Fore	est Hill,	Maryland		
ñ	permit. Departr Imports any inj		Hanguey	n. an	8		ans F	unera	l Chapel and Road Pa	and Creme	ation S	ervices			
ı			28a. Parnt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	Physician /Medical		disease or condition resulting in death)	a. Zym Due/lo (or as a	Dhe		a.						Less Than		
	Examiner		Sequentially list conditions	. Ahae	me	R	•						6 Novelles		
	pet isit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):										
o	an and rial-tra	Examin	that initiated events resulting in death) Last	Due to (or as a c	consequenc	e of):									
09/8c	ficate be executed physician and is the burial-transit	edical	(d											
O. Box 6	death certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	☐ Fetal dea		⊒Ectopic p ⊒ Other (s					23d. Date of o	lelivery Day Year		
rds, P	law requires that the de es been signed by the e 2 should be detached f	þ	Part II. Other significant conditions of	ontributing to death but	not resulting	g in the i	underlying o	cause give	en in Part I.		id tobacco		lo the cause of death?		
Vital Records	0 - 2	Completed			· · · · · · · · · · · · · · · · · · ·						utopsy erformed?	prior t death	autopsy findings available o completion of cause of ?		
VITA	ysician: This certificete	Be	25. Was case referred to medical examiner?	Hoosital.				lou	26. Place of De	ath /Check or	nly one)				
_	d S	5	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day)		Outpatie		DA Othe 28c. Injury Work	4 A Nursing			6 □Other (Sp	pecify)		
NO!	anding sath. or: Afte	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Year)	Injury	м		t? Yes 2□No						
DIVISION	To the Hospital or Attending Ph within 24 hours attended in To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, (Specify)	farm, st	reet, factor	y, office		28f. Location City or	on (Street a Town, Stat	nd Number or e)	Rural Route Number,		
	ne Hosp n 24 hou ne Funer bletely fil	edicai	29a. Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of a hiner: On the basis of ex and manner state	xamination .	lge, dea and/or ir	th occurred rvestigation	at the tim	e, date and place pinion, death occ	e, and due to urred at the tir	the cause(s ne, date an	and manner d place, and d	as stated. ue to the cause(s)		
)	To t To t	×	29b. Signature and title of certifier K	. Tup	wa		. 29	C. License	1060		Fn 12	ate signed (Mo	nth, pay, Year)		
			30. Name and address of berson who o	completed cause of dea	(Item 23) (Type	Print)	se	rel	- 21	23	9.			
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's	s Signature	be	n Kal								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 199, 2010 Clyde 7:40 Leroy Marpoe, Jr. Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center for Hospice Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 01/30/1928 1 ☑ M 2 □ F Months Days Hours Pennsylvania 82 Yrs. **Director** 213-28-3464 Usual Residence of Decedent 28a-f shov 10b. County 10a, State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1325 Fuselage Avenue 21220 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmans. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Warehouse Supervisor Enterprise Elect. Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Pearl E. Martin Clyde Oscar Marpoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Marpoe (Wife) 1325 Fuselage Avenue, Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard. 02/23/2010 Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immunate Cause (Final Physician/ ahoma di ase or condition sulting in death) ase or condition Medical as a nsequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 1 Yes 2 No g 🗌 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital: 1 Yes Other: 2 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 A Other (Specify, 27. Manner of Death

1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) nours after death.

neral Director: After the filled in by the funeral 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending work? 5 Pending iniury 2 🗆 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) within 24 hours a To the Funeral L Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number of person who completed cause of death (Item 23a) (Type, Print) 32. Registra State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland /		artment of Health ar tificate of Death	nd Mental H	ygiene Reg. No 2	10	04858
		н	1. Decedent's Name (First, Middle, Last)			2. Date of I		Year	3. Time of Death
The second	Physici /Medic	al	4a. Facility Name (If not institution, give street and number)	IVIC	Laurin 4b. City, Town, or Location of E	Febru	ary 18	2010	1610 M
	Examin	er	The Johns Hopkins Hospital		Baltimore City			NA	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2X F 7. Age (In yrs. last to 1 M 2X F 54	birthday) Yrs.	Months Days Hours	Min. 8. Date of E (Month, L	irth Day, Year) 19 – 55	9. Birthpl Countr	ace (State or Foreign
	ם		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Loc	cation				Od. Inside City Limits
	a-f she	Director	MD Baltimore Tow	son					1 ☐ Yes 2X No
	with the	Dire	10e. Street and Number 25 Dunvale Road Apt. #456		10f. Zip-Code 21204		10g. Citizen of		ry?
	ems 2%	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, F	n? (Specify Yes or Note:)	n- 14 B:	ce - America	n Indian, tcAfrican
39	ırs after I", or it xamîne	by	XXNever Married 2 ☐ Married 1 ☐ Yes 2 XNo 2 ☐ Yes 2 XNo 2 ☐ Yes 2 XNo 2 ☐ Yes 3 ☐ Yes 2 XNo 2 ☐ Yes 3 ☐ Yes 3 ☐ Yes 2 XNo 2 ☐ Yes 3 ☐ Yes		☐ Yes 2 XNo Specify:		Spec		rican
2-0	be filed within 72 hours after death with the Maryland ttal Hygiene. et al. "I have a sa or 28a-f show event, the Medical Examiner must be notified at event, the Medical Examiner must be notified."	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	dent's Usual Occupation kind of work done during most o	f working	16b. Kind of	Business/Ind	lustry
2121	d within giene. r than the Me	omp	Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade NA		oo NOT use retired) ses Assistar	nt	Stel1	a Mor	ris Hospi
		Be	17. Father's Name (First, Middle, Last) John G. McLaurin			s Name <i>(First, Midd</i> Ls tin e	le, Maiden Surn Bows	,	
aryla	s 1 and 2 should be if Health and Mental item 27 is marked other traumatic ev	ပု		9b. Mailin	ng Address (Street and Number				Code)
	1 and Health Sm 27 ther tr				Midwood Ave	enue Bal	timore		
mor	Pages nent of I nt: If ite		1 Buriai 2 XCremation 3 Removal from State ceme.	etery, crem	natory or other place)	2-22-10			Le, MD
Baltimore,	permit. Pages Department of important: If it any injury or o once.		21. Signature of Funeral Service Licensee		Name and Address of Facility	•	Funera		
	20 2 W OI		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause of each line.		88 N. Gilmor er the mode of dying, such as ca				Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition resulting in death) a. End Stag	e	1	rse			Onset and Death
	/Medical Examiner		the to to as a consequence	e of):	C				
	ed sit	Examiner	Sequestially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	ce of):					
<u> </u>	ate be executed hysician and the burial-transi	Exal	that initiated events c. Due to (or as a consequence)	e of):					
8760	cate be executed physician and sthe burial-transit	edical	d						
POX 6	death certific e attending p ed for use as	an/M	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 1 ☐ Live birth 2 ☐ Fetal dea	ath 3	Ectopic pregnancy			ate of deliver	*
j Ž	the deat y the atte ached fo	Physician/M	in the past 12 months? 1 Yes 2 No 9 Yunknown 1 Unknown		Other (specify)		-	ionth (Day Year
1	v requires that the de been signed by the a should be detached	by Pt	Part II. Other significant conditions contributing to death but not resulting	g in the u	nderlying cause given in Part I.				e cause of death?
Hecords,	w requires that been signed b should be det	eted				24a. Wa	Yes 2 No	3 🔲 Proba	bly 4 ☐ Unknown
		Completed				aut	opsy formed? 2 X No	prior to con death? 1 Yes	npletion of cause of
	Physician: The la this certificate has rral director, page 2	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ inpatient 2 ☐ ER/C	Outpotiont	Othor:	Death (Check only			
n 0T	Phys this ral d	on: To	A	o. Time of Injury		ng Home 5 Res	how injury occu		
UIVISION	ttendir death. stor: Aff y the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At home, i		M 1 ☐ Yes 2 ☐ No et, factory, office		(Street and Nun	nber or Rurai	Route Number,
ź	tal or A rs after al Direct led in b	Certi	4 ☐ Homicide determined building, etc. (Specify)			City or To	wn, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (check only one) 1 Certifying Physician: To the best of my knowledge of the deciral Examiner: On the basis of examination a and manner stated.						
	To the vithin To the comple	Me	29b. Signature and title of certifier		29c. License number	10	29d. Date sign	ed (Month, D	ay, Year)
	}		30. Name and address of person who completed cause of death (Item 23a	a) (Type, F	KED-06	00	reprud	ery /	8,2010
	4		Rina Knatri Johns Hopkins Ho			00 North W	olfe St, B	altimore	e, MD, 21287
	Sta Registr	te	31. Date filed (Month, Day Year) 32. Registrary Signature 33. Registrary Signature	Mes					

DHMH 17 Rev 1/2001

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Villiam Mason		State of Maryland / Department of Certificate of Ce			2010	01.050
Physician	_	Registrar 1. Decedent's Name (First, Middle,Last)	n Death	Reg. 2. Date of Death	No.	3. Time of Death
Medical Examin		William Mason		Month D February 11		2020 hrs
		4a. Facility Name (if not institution, give street and number) Eastbound Route 28@ Hurley Boulevard	4b. City, Town, or Location of Deat Rockville	th	4c. County of Death Montgomery	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr	s. 8. Date of Birth (hplace (State or Foreign
Director		337-78-517) 12M 2DF 62 Yr	Months Days Hours Mi	" Nov 6.	1947 No	th Carolina
a		Usual Residence of Decedent	tion			10d. Inside City Limits
and show any		10a. State 10b. County 10c. City, Town or Loca Rive	enda la			1 Ves 2 No
rylanc sa-f sh	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Coun	try?
th the Maryland 23a or 28a-f she notified at once	=	6831 Riverdale Rd	20738	ν	USI	4
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	- Amed Ferres 15	as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puert		14. Race - Americ White, etc.	can Indian, Black,
er deat	[]	1 Never Married 2 Married 1 V Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 No specify:	,	Specify: BIC	ack_
urs aft tural"	좕	15. Decedent's Education (Specify only highest grade completed) 16a. Decede	ent's Usual Occupation (Give kind of		6b. Kind of Business/Ir	
2 - 2	활	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use re	tired)	Rockvill	la mi
0036 within 72 yiene. her than '	Completed	17. Father's Name (First, Middle, Last)	Doret [18 Mother's Name	ie (First, Middle, Mai		e, 1110
	Se De	John H. Mason	10.Motrier 5 Nami	inknu		
		19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	ng Address (Street and Number or	/ I		
e, MD and 2 sh Health and item 27 is	-	Marylin Vaughan 111224	4 Stolley ler		20c. Location - City or	MD 26874
ore of Herither		1 Burial 2 Cremation 3 Removal from State	other place)	122/2	0 11 1	114
Baltim, Pagpermit. Pag Department Important: injury or o	ŀ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Loensee 22.	Name and Address of Facility	2 1 2010 5	renoleto	n, luc
Balt permit. Depart Impor injury		Min & Africe St. 4	000 Liberty He	ights Av	Le, Balto.	MD 21207
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac	or respiratory arrest,	, shock, or heart	Approximate Interval Between Onset and
Examiner	1	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				Death
	1	b				
	힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
executed an and al - transit	편 교	d				
be e sicial unial	edical	UNPENDED AMENDED			22d Date of delivery	
Box 6876(e death certificate the attending physelofor use as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Figure 1	etal death 3 Ectopic pregn	ancy	23d. Date of delivery Month Di	ay Year
eath ce attend for use	is l		other (Specify)			
t the de ached ached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
P.O. res that the signed by be detach			1.40	1 Yes	2 No 3 Proba	ably 4 🗸 Unknown
Division of Vital Records, P tal or Attending Physician: The law requires t rs after death al Director: After this certificate has been sign left by the funeral director, page 2 should be elected.	Completed	Y		24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
Recc The lav	Ę			performe 1 Y es 2		s 2 No
Vital Rec ysician: The l his certificate l director, page	8	25. Was case referred to medical examiner? Hospital: Inpatient 2 FR/Outnation	26.Place of Death (Check			
ding Physi After this funeral dir	와	1 Yes 2 No Investment 2 ER/Outpatien 27. Manner of Death 28a. Date of Injury 28b. Time of	R 5 DOA TINGS	28d. Describe how	sidence 6 🗸 Other:	
ion creating eath tor: Af the fun	Certification:	1 Natural 5 Pending Feb 11, 2010 ear) 2001 hrs	1 ✓ Yes 2 No	Subject passe vehicle accide	nger of vehicle in	volved in motor
Divisi pital or Att ours after de teral Direct	<u>≅</u>	2 🗸 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	eet, factory, office building, etc.		eet and Number or Run	al Route Number, City
Divis Hospital or A 24 hours after Funeral Directed filled in b	5	4 Homicide determined (Specify) Major Road / Highway 29a. Certifier		Eastbound Route	e 28@ Hurley Boule	evard, Rockvile , MD
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physeophetey filled in by the funeral director, page 2 should be detached for use as the beautified.	Medical	(Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation				
To the within To the comple	ĕ	and manner stated. 29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Mon.	
		Theodon M Kine / Ja. m.)	O.C.M.E.	OGME F	ebruary 12, 2010	0
	f	30. Name and address of person who completed cluse of death (Item 23a)	444 Dec. Otros D. III	MD 04004		
		Theodore M. King, Jr., MD. Assistant Medical Examiner 31. Date filed (Month Day, Year) 32. Egistrar's Signature 33.	111 Penn Street, Baltimor	re, MD 21201	_	
Sta Registra		FEB 22 2010	a stad			

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 10 0 4860 amend #4state of মান্ত্ৰপূপ্ত প্ৰিপ্তৰামিকা কিন্তুৰ নিজ্ঞানিকা And Mental Hygiene

,			ificate of Death	Reg. No.	
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year February 8, 2010	3. Time of Death 1530 hrs
-		Henry Derrick Middleton 4a. Facility Name (if not institution, give street and number) 601 Winesak Avenue, Apartment 320	4b. City, Town, or Location of Deat	h 4c. County of	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	Baltimore st birthday)		A 9. Birthplace (State or
Director		214-94-9237 _{134 2 F} 42	Yrs. Months Days Hours Mir		
any		Usual Residence of Decedent 10a. State 10b. County 10c. City. T	Town or Location	-	10d. Inside City Limits
8 .	_		altimore		1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number Apt. 320	10f. Zip Code	10g. Citizen of Wha	t Country?
0036 within 72 hours after death with the Maryland jiene. her than "natural", or items 23a or 28a-f she. Medical Examiner must be notified at once.		601 Wyanoke Avenue 112. Was Decedent Ever in U.S	21218	USA	American Indian, Black,
death w	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto		
	by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify: 16a. Decedent's Usual Occupation (Give kind of		Black
72 hour matu	eted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ref	tired)	e Industry
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner.	Completed	12th grade	Counselor		
215-(e filed v tal Hygi ked oth nt, the	Be C	17. Father's Name (First, Middle, Last) William H. Middleton, Jr.	Edie L.	e (First, Middle, Maiden Surname)	
	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or	Rural Route Number, City or Town,	
imore, MD 2 Pages 1 and 2 shoument of Health and Nant: If item 27 is no other traumatic			5356 Cordelia Aver	nue Baltimore, Date 20c. Location - C	Maryland City or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite			ematory or other place) odlawn Cemetery 2,	/16/10 Woodlaw	n,Maryland
Baltimord permit. Pages 1 Departament of P Important: If	7	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Cha	atman-Harris F	uneral Home
Physician	4	23a, Part I. Entey the disease, or complications that caused the death. I	i 5240 Reistersto	<u>own Rd Baltimo</u>	ore,MD 21215
'Medical aminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Heart Dise	ase		Between Onset and Death
.aminor		or condition resulting in death) Due to (or as a consequence of): b.			
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
ii d	Examiner	(Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of):			
executed in and 1 - trans		d. UNPENDED AMENDED			
760, icate be executed physician and the burial - transit	Medica	IF FEMALE: 23c. If yes, outcome of pregna	ancy	23d. Date of d	elivery
Ox 687 ath certific attending p		23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of dear	2 Fetal death 3 Ectopic pregn	ancy Month	Day Year
J. Box 68 t the death certifi by the attending	Physician	1 Yes 2 No 9 Unknown 9 Unknown	Uther (Specify)		
Records, P.O. Box 68760, The law requires that the death certificate becate has been signed by the attending physicii page 2 should be detached for use as the burit		Part II. Other significant conditions contributing to death but not res Supraventricular tachycardia	sulting in the underlying cause given in Part I.	23e. Did tobacco use contrib	ute to the cause of death? Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	Completed by				ere autopsy findings available or to completion of cause of
tal Reco	mo				ath? Yes 2 No
n of Vital I ding Physician: h. After this certifi funeral director,	B	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 E	26.Place of Death (Check Properties of Death (Check Properties 1 DOA Potter Nursi	only one) ng Home 5 Residence 6 ✔	Other: Scene
Division of Vital pital or Attending Physician: ours after death. eral Director: After this certifilled in by the funeral director.	n: 7	27. Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
Sion Attendi death. ector:	catio	Pending Accident Investigation	1 Yes 2 No		B 18 1 N 1 0
Divisus after Ital or A	Certification:	3 Suicide 6 Could not be determined (Specify)	ne, farm, street, factory, office building, etc.	28f. Location (Street and Number or Town, State)	or Rural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifying Physician: To the best of my knowledge			
To th withi To th	Medical	one) 2 Medical Examiner: On the basis of examination and and manner stated. 29b_Signature and title of certifier	29c. License number		(Month, Day, Year)
		DT (- 180-1	O.C.M.E.	February 9,	2010
	Ì	30. Name and address of person who completed cause of death (Item 2	·	re MD 21201	
St	ate	Patricia Aronica-Pollak MD. Assistant Medical E. 31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regist			aid		
DHMH 17 Rev 1/2	001	7	ORIGINAL	OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Merri 13:12 BW February 2010 20 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Seasons Hospice Randa11stown 8. Date of Birth (Month, Day, Year) Oct. 27, 1927 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months XXM 2 F Days Hours 220-20-4867 82 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 🗶 🗙 No MD Baltimore Reisterstown 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 22 Wabash Ave. 21136 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc YYes 2 No li Yes, Give Year or Dates: 1 Never Married XXMarried 1 ☐ Yes XXNo Specify: Specify: White WW II 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Westinghouse Elementary/Secondary (0-12) College (1-4or 5+) Electric Logistics Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas W. Merriken, Sr. Edith L. Stapf 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Wabash Ave. Reisterstown, MD 21136 Mary Merriken / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State Maryland veterans ¢em. 3/4/10 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licensee 11605 Reisterstown Rd. Owings Mills, MD21117 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final raumatic disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? ronic autopsy performed? 1 □ Yes 2 🗷 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1′⊠Yes 2 🗆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 🗓 No 9/10/2009 off ladder 2 Accident 3:00 Fell 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Box 68760.

the death certificate be executed attending physician and for use as the burial-trar d by the a

Physician/Medical þ Completed Be Medical Certification: To

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highly or other traumatic event, I'm Modical Examinat must be notified at once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records,	the Hospital or Attending Physician: The law requires the	ne Funeral Director: After this certificate has been signer ipletely filled in by the funeral director, page 2 should be d
o	Phy	raldi
Division	the Hospital or Attending	runeral Director: And stely filled in by the fune
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State Registrar

31. Date filed (Month, Day, Year)

Seay

FEB 2 2 2010

4 Homicide

(Check only

29a. Certifier

one)

29b. Signature and title of certifier

29c. License number D0053337

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Reisterstown

md 21136

February 20, 2010

22 Wabash Avenue

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Home

2835 Smith Avenue Suite 203 Baltimore, Md 21209 32. Registrar's Signature

arked

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04862 Reg. No. 2 () Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2113 David Joseph Mansfield 2019 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death Baltimore 8. Date of Birth (Month, Day, Year) Country) 16, 1947 Newfoundland Social Security Number 7. Age (In yrs. last birthday) Funeral If Under 24 Hrs. 9. Birthplace (State or Foreign 1 XM 2 🗆 F Months Days Hours 204-38-0845 Director 62 Yrs Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Parkville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 21234 27 Primrose Court USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural" 3 Widowed 4 Divorced Specify: white Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Botany 500 12 Manufacturing permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If Rem 27 is marked othe any injury or other traumore. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Roland Mansfield Beatrice Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Kline -daughter 27 Primrose Court-Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland ans Funeral Channel and Feb. 25, 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Evans Funeral Chapel 8800 Harford Road-Parky and Cremation le, Maryland, 2123 Fer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of):
(ASCULGR DISCO Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy performed?
Yes 2 No 25. Was case referred to medical examiner?

1 V2 Yes 2 \[\sum \text{No} \] B 26. Place of Death (Check only one) ြု Other: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) in 24 hours after deau...

In 24 hours after deau...

In Euneral Director: After the funeral on by the funeral or an angle of the funeral or and an angle of the funeral or angle or angle of the funeral or angle of the funeral or angle of the funeral or angle of the funeral or angle of the funeral or angle of the funeral or angle of the funeral or angle of the fune 27. Manger of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred M Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Coertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signa 29c. License numbe son who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEBRUARY 2010 NIDO 6:35 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 06/14/1923 Maryland Director 218-14-0488 86 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must have material. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Bel Air 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1403 Bonnett Place, Unit "E" 21015 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 XWidowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ecrole Lombardi Clara Minolti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1403 Bonnett Place, Unit "E", Bel Air, Md. 21015 Clara DelGallo (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Holly Hill Mem. Gard. 02/22/2010 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Septice Licensee 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A.
1407 old Eastern Avenue, Essex, Maryland 21221 23a: Part 1 There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Approximate Interval Between Immediate Cause (Final disasse or condition resulting in death) Onset and Death Physician/ TO Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 1 Yes 2 No 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital 2 No Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation Accident after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral C Medical Qertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) Febru 32299 2011

State Registrar DHMH 17 Rev 7/2009 DAVID DUNN

31. Date filed (Month, Day, Year)

FEB 22 2010

BEL AIR, MD.

21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 W. MACPHAIL ROAD

32. Registrar's Signature

FEBRUARY 22, 2010 9:48 a.m.

LOUISE REYNOLDS

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.												
			For State	State of Ma	arylan		artment of F		Mental Hy	giene	0010	010	C 1
			Registrar 1. Decedent's Name (First, Middle, La	not)		Cer	tificate of L	Death		Reg. No	0. 2 1 1	1 048	04
	Physicia Medic		Louise H. Reynol	ds					2. Date of De Month Februar		2, 2010	3. Time of De 9:48	ath AM
	Examin	er	4a. Facility Name (if not institution, glv Stella Maris Hosp	,			4b. City, Town, or Timo	Location of Death	1	4c. County of Death Baltimore			
	Funeral Director			Sex 1 □ M 2 🖾 F 8		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	h y, Yea <i>r</i>)	CC	rthplace (State or Fo buntry) W York	o <i>r</i> eign	
1	ind show at		Usual Residence of Decedent 10a. State 10b. County			y, Town or Loc	cation		0 000 2)	10d. Inside City L	imits
	e Maryla r 28a-f s notified	Director	Maryland Baltim	ore		Esse	10f. Zip Code					1 🗆 Yes 2	₩ No
	vith th		1900 Grove Manor	Dr. Apt. 42	28		212	221		Tug. C	itizen of What C	ountry?	
	tems r mu	Funeral	11. Marital Status	12. Was Decedent E			Was Decedent of Hispanic Origin? (Specify Yes or Not f Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - Ame		
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show ampiriumy or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 If Yes, Give Year or Dates.	No		Yes 2 X No		o Alcan, etc.)		Black, White Specify: W	nite	
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2	d withing ygiene her the the the the the her t		10]	Inspector		-		Westing	ghouse	
Baltimore, Maryland	ld be filed Mental H arked ot atic ever	To Be	17. Father's Name (First, Middle, Last) Michael Grieco						ne (First, Middle, a Orland		Surname)		
Mar	d 2 shou alth and 27 is m or traum		19a. Informant's Name/Relationship (Thomas A. Reynold	** *			ng Address (Street a					ip Code) and 21220	j
nore,	age 1 and and of He It it it item		20a. Method of Disposition 1 ☐ Burial 2 ※ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec		0	emetery, cren	sition (Name of natory or other place rematory	re)	Date / 2010		ocation - City o	Town, State Maryland	
Baltir	permit. P. Departme Importar any injur.		21. Signature of Funeral Service Ligarity		рау	22 B 1	. Name and Addres	ss of Facility	l Home I	- Δ			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										Approximate Interval Between			
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Dun to (or en e	nonsequ	innañ c'h						4	
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3760	ficate g phys	/ledi		d									
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral inferor. After this certificate has been signed by the attending physici for the Funeral linector. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of the line of the li	2 🗌 Feta	Ideath 3	Ectopic pregnanc Other (specify)	у			23d. Date of de Month	elivery Day Year	r
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Be	ding Physician: The law Ih. h. Affer this certificate has t funeral director, page 2 s	Con							perfo	rmed? 2 X N	death?	s 2 🗆 No	
ţa	sician certifi rector	Be o	25. Was case referred to medical examiner? 1 ☐ Yes 2 🖾 No	Hospital:			_ Oth	ace of Death <i>(Che</i> er:			700	HOGDIO	
of V	g Physer this eral di	e: To	27. Manner of Death	28a. Date of injur	у	ER/Outpatien 28b. Time of	28c. Injun	y at	lome 5 Resid			cify) HOSPIC	<u>e</u>
Ou	ending sath. or: Afte he fun	ficat	1 Matural 5 ☐ Pending 2 ☐ Accident Investigatic 3 ☐ Sulcide 6 ☐ Could not		, rear)	injury	M 1 □	Yes 2 No			=- =		
Division of Vital Records,	To the Hospital or Attendii within 24 hours after death. To the Funeral Director. Al completed filled in by the fu	Il Certificate;	4 Homicide determined				eet, factory, office		28f, Location (S City or Tow			ıral Route Number,	
	e Hospit 24 hour e Funera	Medical	(Check 2 Medical Exam	ysician: To the best of oniner: On the basis of exercioner: To the	kamination	and/or invest	igation, in my opinio	on, death occurred	at the time, date a	ind place	e, and due to the	cause(s) and manne	er stated.
	To the To the Comp.		29b. Signature and the of certifier	m CANP			29c. License				ate signed (Mont		
	11			completed cause of de				1(1)		4	cojo	, –	
	Stat		31. Date filed (Month, Day, Year)	32. Registra	r's Signat	ure	LLEY RD.	TIMONIU	JM, MD 2	1093	3		
DU	Registra		FEB 22 2010	Chron	B.	park					<u></u>		
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Jos	shua Edw	vard		1- For State Registrar	d / Department of Certificate of	of Health ar	-	/giene	2010 g. No.	0486		
Me	Phy dical Ex	/sicia kami	an/	1. Decedent's Name (First, Middle,Last) Joshua Edward Roskove	enskv			Date of Death Month February 1	Day Year	3. Time of Death 1423 hrs		
				4a. Facility Name (if not institution, give street and number 7416 Centre Street		4b. City, Town, o	or Location of Death	T CDITURY I	4c. County of Deat	n .		
	Fund			5. Social Security Number 215-35-1236 6. Sex 7	Age (In yrs. last birthday)	If Under 1 Ye	ear If Under 24Hrs.	-	Eoroi	rthplace (State or gn puntry) MD		
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	al", or items 23a or 28a-f show any iner must be notified at once.	by Funeral Director	1 X Never Married 2 Married Armed Force 1 Yes 3 Widowed 4 Divorced If Yes, Give Year or Dates:	es? If 2 No 1	e 10f. Zip Code 21784 as Decedent of H Yes, specify Cuba	. ,	ecify Yes or No- Rican, etc.)	g. Citizen of What Cou USA 14. Race - Amer White, etc. Specify: Whit	ican Indian, Black,		
	5-0036 iled within 72 hours Hygiene.	other than "natur the Medical Exam	mpleted	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12) College (1-4) 17. Father's Name (First, Middle, Last)	or 5+) during r		ation (Give kind of we feel DO NOT use retired in the control of t	16b. Kind of Business/ Stee1 aiden Surname)	Industry			
	MD 2121(27 is marked imatic event, 1	BB	Thomas Roskovensky 19a. Informant's Name/Relationship (Type, Print) Mr. Thomas Roskovensky (f					per, City or Town, State	e, Zip Code)		
	Baltimore, Normania. Pages 1 and Department of Health	tant: If item or other trau		20a Method of Disposition 1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other Specify:	All Count	therplace) y Cremat	ion 2-1	Date 9-10	20c, Location - City or Sykesville	e, MD		
	Ball permit Depart	Impor injury		21 Signature of Funeral Service Licensee Pargustaignt Struber	t P	.O. Box	195 Sykes	ville, l		Chapel		
4	Physic / /Medi Exami	ical	Examiner	23a. Part I. Enter the disease, or complications that caus failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the cause of the	shot Wound of Head insequence of):	tne mode of dying	g, such as cardiac of	respiratory arre	st, snock, or neart	Approximate Interval Between Onset and Death		
X	0, be executed	an and al - tra	lical	UNPENDED AMENDED								
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.	ne attending physica I for use as the buri	hysician/Mec	23b. Was decedent pregnant in the past 12 months?	t at time of death 5 0	etal death 3 other (Specify)	Ectopic pregnar	ncy	23d. Date of deliver	y Day Year		
	, P.O. I	signed by the a	by P	Part II. Other significant conditions contributing to d	eath but not resulting in the	underlying cause	given in Part I.		pacco use contribute to			
	Division of Vital Records, talor Attending Physician: The law requirers after death	ficate has been s ; page 2 should t	Completed					24a. Was ar autops perform 1 Yes 2	y prior to oned? death?	topsy findings available completion of cause of es 2 No		
	/ital	his certifi director,	ď	25. Was case referred to medical examiner?	atient 2 ER/Outpatien		Other Nursing		Residence 6 🗸 Other	" Scene		
	on of V	r: After th	ication: To	27. Manner of Death Natural 5 Pending Pending	Injury 28b. Time of FOUND:	Injury 28c. Inju	ury at Work?		ow injury occurred			
	Division Attenter after de	rai Directo lled in by t	Certifica	Suicide Could not be	10 1413 hrs f Injury - At home, farm, stre Single Family	eet, factory, office	•	or Town, Sta	reet and Number or Ru ate) creet, Sykesville, MD	ral Route Number, City		
0	o the Hosp ithin 24 hou	To the Funeral Director: completely filled in by the		29a Certifier 1 Certifying Physician: To the best of (Check only one) 2 Medical Examiner: On the basis of and manner state	examination and/or investiga							
	E 38 E	1 8	2	296 Signature and title of certifier M. Brasse (M)			se number		29d. Date signed (Mo. February 16, 201			
				 Narfe and address of person who completed cause Melissa Brassell, MD Assistant Medical 		Penn Street, I	Baltimore, MD 2	21201				
		Sta	ate	31. Date filed (Monte PD Y57) 2010 32. Pgis	trar's Signature	aked						

DHMH 17 Rev 1/2001 OCME 2006

OCME

10-00935 Flijah Randolph

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2010 04866

ijan Kandoipii	1-	- For State Critificate of Death	Reg	. No	
Physicia		edistrar 1. Decedent's Name (First, Middle, Last)	Date of Death Month	Day Year	3. Time of Death
al Examir	177	Elijah Randolph	February 2,	2010	0016 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	h	4c. County of I	Death
		727 Druid Park Lake Drive Apt. 8K Baltimore		N	H
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs		, IF	9. Birthplace (State or oreign
Director		213-70-01008 17 2 F 51 Yrs. Months Days Hours Mir	1 Feb 11	2 1958	Country) North (choice
	6	Usual Residence of Decedent	1		
any		10a. State 10b. County 1 10c. City, Town or Location			10d. Inside City Limits
* .		MD NA Baitimole			1 Xes 2 No
Maryland 28a-f show d at once.	힐	10e, Street and Number	100	g. Citizen of What	Country?
Mary r 28a	Director	The sheet and North Lake A 21217		11.	SA
with the Maryland ns 23a or 28a-f she be notified at once		11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No-	14. Race - /	American Indian, Black,
ath with the items 23a		Armed Forces? If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	White,	etc.
deat or it	긢	Yes Z No		Specify:	Black
after	<u>a</u>	Wildowed 4 Divorced If Yes, Give Year 1 Test 2 W No Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	work done	16b. Kind of Busin	ness/Industry
hours natu Exam	g -	during most of working life. DO NOT use re	etired)		1 1
36 thin 72 te. than "	et	1) GODA		1):3	sable
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed		ne (First, Middle, M	aiden Surname)	1.
		Fligh Rondolph Ss.	a Ru	th H	tines
21215-0036 Auld be filed within 7 Mental Hygiene. marked other than	Be	19a. Informant's Name/Relationship (Type, Print)	Rural Route Num	ber, City or Town,	State, Zip Code)
- 0 D S =	2	-1 -1 D. 1.006 C. Ithan 12 11 17th Street	Pinet	005, N	1C 27864
e, MD and 2 short Health and item 27 is		20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date /	20c. Location - C	City or Town, State
or He the the the the the the the the the th	- 1	1 Burial 2 Cremation 3 Removal from State crematory or other place)	10/200	Poll	amora Mi
Page nent ant:		4 Dogation 5 Other Specify: Metro Crematory 2	18/2610	Dua	no theme
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other t	J	21. S ure of Funeral S ice Licen 22. Name and Address of F lity	SWEDD	- CENTRAL	Batro MD 21207
o 59 E E		Then K. How See Hoo Liberty F	or resiliatory arre		
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as failure. List only one cause on each line.			Between Onset and
/Medical		Immediate Cause (Final disease a Hypertensive atherosclerotic cardio	vascular	disease	500.11
≟xaminer		or condition resulting in death) Due to (or as a consequence of):			
		Sequentially list conditions, b.			
	Je l	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
	Physician/Medical Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	ical	$\boxed{\mathbf{X}}$ UNPENDED $\boxed{}$ AMENDED 23a, 27, per ME g900 2/24/10 T	ידי		
60, ate be hysici e buri	led	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of	
876 iifical ng ph	n/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fedal death 3 Ectopic preg	gnancy	Month	Day Year
Box 687 e death certifice the attending p ed for use as th	icia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			
Bo) deat he at	l Sc	1 Yes 2 No 9 Unknown 9 Unknown	23e Did to	phacco use contrib	oute to the cause of death?
O. O. B that the d ned by the detached	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			Probably 4 🗸 Unknown
Records, P.O. Box The law requires that the death icate has been signed by the atte page 2 should be deached for t	d by		- 120-2900		Vere autopsy findings available
ds required required required	ete		24a. Was autop	osy p	rior to completion of cause of
COI law has	ᇛ		perfo 1 ✓ Yes		eath? ✓ Yes 2 No
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F V; Physi r this	ြို	1 V Yes 2 No 28b. Time of Injury 28c. Injury at Work?		how injury occurre	
Ing I		1 X Natural 5 Pending (Month, Day, Year)	ļ		
Division ospital or Attend hours after death.	Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number	er or Rural Route Number, City
ViS or Au fifer of Direction by	≝	3 Suicide 6 Could not be	or Town,		
Di Hospital 24 hours a Funeral	Ser	4 Homicide determined (Specify)		as(a) and manner	ne stated
Hos 24 h Fun	_		and due to the cau ed at the time, date	e and place, and d	ue to the cause(s)
Division of Vital E To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certificompletely filled in by the finneral director,	Medical	one) 2 Medical Examiner: On the basis of examination and on the sugarion, with a specific part of the basis of examination and on the sugarion, with a specific part of the basis of examination and on the sugarion, with a specific part of the basis of examination and on the sugarion, with a specific part of the basis of examination and on the sugarion and on the basis of examination and on the sugarion and on the basis of examination and on the sugarion and on the basis of examination and on the basis of e			ed (Month, Day, Year)
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		That Me Kill TR. 144 V			, =
		30. Name and address of person who complet of cause of der th (Item 23a)	MD 0400	1	
		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltim	nore, MD 2120	' 1	
ij.	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
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			For	State of Maryland /			ntal Hygiene	010	01.967
			State Registrar	-41	Certificate of L		Reg. No.	UIU	3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, La	SMALL			Month Day	Year 20 10	IC) nd a M
	/Medio		4a. Facility Name (If not institution, giv		4b. City, Town, or			County of Death	1.34
*			Northwest	Itospital	Band	allston	un	Balti	more
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. last bi	Yrs. If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Year)	Coun	place (State or Foreign
	Director		Usual Residence of Decedent	10		1000	19,193		.5C
irvlan	show	_	10a. State 10b. County	10c. City, Tow	n or Location			11	0d. Inside City Limits 1 X es 2 □ No
the M	28a-f	ecto	10e. Street and Number		Bal-+16	nore	10g Citiz	en of What Coun	
Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be natified at once.	Funeral Director	3401 Kesto	n Bd	31	207	109. 0.02	USA	,
death	ems 2	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His If Yes, specify Cubar		Yes or No- 1-	4. Race - Americ Black, White, e	
affer	or ite	by Fu	1 Never Married 2 Married	1 Yes 2 No From		Specify:		Specify:	310.
lours of	itural"		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	a. Decedent's Usual Occupa	ation	16b. Kin	d of Business/Inc	dustry
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should	nd Me mark imatic	၉	19a. Informant's Name/Relationship (Type. Print), 19	b. Mailing Address (Street a		oute Number, City or	Town, State, Zip	Code)
and 2	altha 127 is ertrau		Deloves Smo	ill wife 3	401 Keste	on Bd B	altimor	e, MT	2007
es 1 se	of He or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	20b. Place of	of Disposition (Name of ery, crematory or other place	Date		ation - City or To	
t, Pao	tment tant:		4 □ Donation 5 □ Other (Specif	we wer	ro Crematori	\	Bat	fimor	e, MD
	Depar Impor any In		21. Signature of Puneral Service Licer	ISEG	22. Name and Addres	sof Facility 338 Midval	100 50 -		M volumet
			23a. Part 1. Enter the disease, or com	lications that caused the death. Do	not enter the mode of dying			Jessoly 1	Approximate Interval Between
P	nysician		shock, heart failure. List only Immediat Cause (Final disease or condition	one cause on each line. Atthrosizent	ic Common	anter	Y Disc	ale	Onset and Death
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death	e atter	iciar	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq Yes \) 2 \(\subseteq No \)	1 ☐ Live birth 2 ☐ Fetal death	h 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	·		Month	Day Year
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requi	been si should t	Completed					24a. Was an		opsy findings available
he law	cate has page 2 s	Jdwo					autopsy performed2	prior to co death?	mpletion of cause of
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Attending Physician:	th. : After this certifice : funeral director, p	To B	examiner? 1 ☐ Yes 2 No		othe	4 LINUISHIG Home	5 ☐ Residence 6	□Other (Specif	fy)
ling P	After t funera	ion:	27. Manner of Seath 1 □ Natural 5 □ Pending	(Month, Day, Year)	Time of Injury Work	/at 28d ? /es 2 □ No	. Describe how injury	occurred	
Attenc	death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not b	e 29e Place of Injury. At home fr			Location (Street and	Number or Rura	al Route Number,
alor	s after al Dire	Certification:	4 Homicide determined	building, etc. (Specify)			City or Town, State)		
lospit	t hour unera ely fille	edical (nysician: To the best of my knowledg					
the F	within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Medi	29b. Signature and title of certifier	and manner stated.	29c. License			signed (Month,	
P	× 500	_	for M.C.	\	1000		Rela	V274 9	Th 2010
•			30. Name and address of person who	completed cause of death (Item 23a)		1 7 6 7 30	1	0	1 2010
			5HO1 OLA	Count Ro	ad Ando	Michael	Mary (ord	21133

Registrar

State

31. Date filed (Month, Day, Year) FEB 22 2010

berter

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Billy Clarence Smith February 19, 2010 12:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Elkton Care & Rehabilitation Center Elkton Cecil 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 € M 2 🗆 F 219-32-9990 Director West Virginia 02/02/1934 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Wedich Erain in 17, ust be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Cecil Elkton Director 1 ☐Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40 Julia Marie Court 21921 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2X No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker Auto Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alex Smith ပ Stella Lipinski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Zeauskas (Niece) 40 Julia Marie Court, Elkton, Maryland 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) HE Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 02/22/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Imm te Cause (Final Physician COPD 7 RESPIRADLY dis se or condition re ulting in death) /Medical Due to (or as a consequence of): Examiner TRIAL Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed MYOCAMDIAL attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical CONGESTIVE IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an nis certificate has director, page 2 autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) r this r 1 Yes 2 No Certification: To After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P.V. Naye

State Registrar

MARAYANA 31. Date filed (Month, Day, Year)

32. Registrar's Signature

nD

V- PULA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 1/2001

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MD 21921

F. HIGH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04869 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Shirley Sekinger Year 1:08PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GOOD SAMARITAN HOSPITA Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Mattern 49, 1922 Mary Tand 215-12-9751 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Funeral Director N/A Maryland Baltimore 1X Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? 2405 Hamilton Avenue 21214 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by 1 X Never Married 2 Married Yes 2 X No Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Lepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event" and once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant 2 Education Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William O. Sekinger Nellie Meek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Peck, Jr., Esq./ Attorney 304 W. Pennsyvlania Avenue Towson Maryland 21204 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Jessup United Meth. Cem. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2/25/10 Cockeysville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HTRACRAHIAL disease or condition BLEFDING Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and the attending physician and thed for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 29b. Signature and title of certified 29c. License number atish Kabra MD RES-000 FEB 19 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN BOULEVARD BACTEMORE MD21239 31. Date filed (Month, Day, Year) State FEB 22 2010 Registrar

DHMH 17 Rev 7/2009

SHIRLEY

111

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ng. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** amue 5: 10 AM bruan 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Himor lew If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 213-62-6100 Director ncent Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event; the "Modeal Examiner mast be notified at 1 ☐ Yes 2 ☐ No Director altimor 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21218 Funeral [12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 6 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Black þ 3 Widowed 4 Novorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life., DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ne any injury or other traumatic event, the March ance. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be amue ည Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jolph samul Son rlengyle altimore MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 Removal from State saltimore 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses towell MD 21207 4600 Heights Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Corevala disease or condition resulting in death) me /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 2 No 1 ☐ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **W** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) Type, Print) SALWAMD 6821 Reistentun PD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 1600 Antonio Reco Smith 2010 Feb Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 3916 Fairview Avenue Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 52 Yrs. 8. Date of Birth (Month, Day, Year 5. Social Security Number **Funeral** Days 217-74-5784 Director 20,1957 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Director Baltimore 1 X Yes 2 No N/A Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21216 Funeral 3916 Fairview Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11, Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates SpecifBlack 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Flementary/Seconday (0-12) College (1-4 or 5+) Unemployed 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elaine Corbin Charles O. smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 276 S. Monastery Avenue Baltimore, Maryland 19a. Informant's Name/Relationship (Type, Print) Catina M. Jones/ Daughter injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important; If ite
any injury or oth 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery 19/10 Baltimore, Maryland 22. Name and Address of Facility Chatman . Signatur of Funeral Service Lice Harris Funeral Home Baltimore,MD 21215 5240 Reisterstown 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Phylician/ End 5 + a ...
Due to (or as a consequence of). disease or condition Medical resulting in death) Examiner , a bete Sequentially list conditions, Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Diserto for as a nonsectionne offi 20405 attending physician and I for use as the burial-transit 000 that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ I or Attending Physician: The law requires after death.

Director: After this certificate has been sign 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 1 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Certificate: To Be examiner? Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital o 24 hours af Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 38747 2/18/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 516 N. Rolling Road Suite 107 Behrens MD 31. Date filed (Month, Day, Year) strar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** 12:00 AM IOHN LEONARY SIGLER FB 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HAVEN NURSINGHOME BALTIMORE CATONSVILLE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country)
MARYLAND 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) OEC 19 19 Social Security Number 6. Sex **Funeral** Days 219 38 9883 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State show r 28a-f show notified at 1 ☐ Yes 2 No MO BALTIMORE CATONSVILLE Director 10e. Street and Number 10g. Citizen of What Country? ed other than "natural", or Items 23a or event, the Medical Examiner must be r EDMONOSON 2122 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 212 No WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) KOUNS FORN MECHANIC 12 should be filed whand Mental Hygien is marked other the 17. Father's Name (First, Middle, Last) . 1 and 2 should be t Health and M JOHN L. SIGLER. CAMILLE SHAFFER ALICE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA J SIGLER/WIFE 500 KINGDOM COURT ODENTON MD Department of Health Important: If Item 27 any Injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ABurial 2 □ Cremation 3 □ Removal from State EVERGREEN MEM GAR 2/24/2010 FINKSBURG, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility V N ZUMBMN FH & MON CO 21. Signature of Funeral Service Licensee

22. Name and Address of Facility VNZUMBWA

COLD SYKESVILLE RD EADER

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6028 SYKESVILLE RD ELDERSBURG MO 21784 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MELLHONIA 4 DAYS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 □ Pregnant at time of death 5 Other (specify) P.O. 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 2 Accident completely filled in by the 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Paysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier R088852

Sta

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**YATHUSSN.C. DIAMOND Z835 SMITH AUE #203 (SOUTHOUS), UD 21209.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

31. Date filed (Month, Day, Year) FEB 2 2 2010 Level B. Sake

I0-01158 Eugene Sanders	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene										
		1- For State Certificate		Reg	2010	0487					
Physicia Medical Exami		Liverne Lamont Sanders		Date of Death Month February 8,	Day Year 2010	3. Time of Death 1550 hrs					
		4a. Facility Name (if not institution, give street and number) 2710 W. Baltimore Street	4b. City, Town, or Location of Deatl Baltimore	h	4c. County of Death	1					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Mir	_	(MM/DD/YYYY) 9. Bir Foreig	in h 4 m					
b		Usual Residence of Decedent	Yrs.	100/11	71901 0	untry) V).					
nd show any ce.	L	10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits 1 X Yes 2 No					
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	10f. Zip Code	10g	g. Citizen of What Cou	ntry?					
with the s 23a or		11. Marital Status 12. Was Decedent Ever in U.S. 13.	QQQ3 Was Decedent of Hispanic Origin? (S	necify Yes or No-	14 Page - Ameri	ican Indian, Black,					
r death v	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	carringan, place,					
ours afte	þ		Yes 2 No specify: dent's Usual Occupation (Give kind of		Specify: (LC K ndustry					
215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medreal Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NOT use ret	ired)	Baltimore	Altu Ilan					
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Com	17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, Ma	butimmel iden Surname)	City HOSP.					
T = 2 = 5	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or	V Smr	er. City or Town, State	Zip Code)					
AD 2 sho		Lillian lude/Mother 1231:	5 Ruscombe Lane	. Baltimo	re, MD. 2	1215					
nore, Nages I and nt of Healtlit. If item other trau		1 Burial 2 Cremation 3 Removal from State crematory of	position (Name of cemetery, other place)	Date	20c Location - City or	Town, State					
Baltimore, permit. Pages I a Department of He Important: If ite		4 Donation 5 Other Specify: 21. Signature of Euneral Service Licensee	2. Name and Address of Facility	<u>XZ1X01011</u> LmWn-mo	DUTTILLE LE LIMS FUNLLE	y NID. W Home					
ம் இத்தத் Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter	240 RUSTUSTOM	Road by	utimore, m). 21215 Approximate Interval					
/Medical	1	failure. List only one cause on each line. Immediate Cause (Final disease a. <u>Cardiac Hypertroph</u>		arroopo.or, arroo	, onest, or near	Between Onset end Death					
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b									
	Examiner	if any, leading to immediate Due to (or as a consequence of):									
ecuted and transit	Exan										
S E	dical	x UNPENDED AMENDED 23a,pt.II,27 per me g901 3-25-10 vt									
ox 68760, rath certificate be ex attending physician for use as the burial	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregna	ancy	23d. Date of delivery Month D)ay Year					
	Physician/Medical	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	Other (Specify)								
ires that the d		Part II. Other significant conditions contributing to death but not resulting in the			acco use contribute to						
ords, F	eted	Obesity, Thyroid Disease, Steroid		1 Yes	2 No 3 Prob	topsy findings available					
Division of Vital Records, tal or Attending Physician: The law requirers after death. In Director: After this certificate has been sived in by the funeral director, page 2 should be a burner or the funeral director.	Completed by	Atherosclerotic Cardiovascular Dis	sease	autopsy perform 1 ✓ Yes 2	ed? death?	completion of cause of					
ital Recidina: The last certificate lirector, page	Be	25. Was case referred to medical examiner? Hospital: Inpatient 2 ER/Outpatient	26 Place of Death (Check								
1 of Vi	n: To	1 ✓ Yes 2 No Impatin 2 Erroutpath 27. Manner of Death 28a. Date of Injury 28b. Time of Death		28d. Describe how	esidence 6 🗹 Other w injury occurred	: Scene					
Sion Attendir death. ector: by the f	ertification:	2 Accident Investigation 28e Place of Injury At home farms:	1 Yes 2 No	29f Location (Str	not and Number of Du	ral Route Number, City					
Div pital or ours afte	Certif	4 Homicide determined (Specify)	reet, ractory, onice building, etc.	or Town, Stat		— —					
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death ocone) 2 Medical Examiner: On the basis of examination and/or investi									
To To Con	Mec	29b. Signature and fittle of certifier	29c. License number	2	29d. Date signed (Mor	nth, Day, Year)					
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		February 9, 2010						
		Victor Weedn MD JD Assistant Medical Examiner 111	Penn Street, Baltimore, MD	21201							
Sta Registi	ate rar										

DHMH 17 Rev 1/2001 OCME 2006

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AMEND ITEM#11 perFH, G902, 4/1972010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last)
Marie C. Stahl 2. Date of Death Physician/ 2716/2018 22:26 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomerv Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 PA **Funeral** 187-28-9454 1 🗆 M 2 🔀 F Months Days Hours 74 (Month, Day, Year) Director Usual Residence of Decedent miporation in term 2/1s marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Montgomery MD Silver Spring Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? by Funeral 3115 Farnborough Ct 20906 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married 72 hours after 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. Completed 3 Widowed 4 Diverged 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 0 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Mary Murphy ဂ္ James J. Fee Released 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3115 Farnborough Ct, Silver Spring MD 20906 Joseph Stahl / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 2/22/10 Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Bensalem, PA 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 re of Euneral Service Licensee Victor Doda ico 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pheumonia Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence on Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 nknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy the Hospital or Attending Physician: The I hin 24 hours after death. the Funeral Director: After this certificate h performed? Yes 2 1 No 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2XXNo 1 🗌 Yes Other: ပ္ 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 \(\sum Yes\) Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗋 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and titlero 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) 30 Name and Suburban HOspital Bethesda, MD 31. Date filed (Month, Day, Year) State 32. B FEB 22 2010 Registrar

Examiner

Medical

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 17 2010 HERBERT 04:30 AM HENRY SCHERR Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SUNRISE ASSISTED LIVING BALTIMORE PIKESVILLE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) MD Social Security Number 7. Age (In vrs. last birthday 8 Date of Birth Funeral 1 X M 2 □ F Min 88 Yrs 0370871921 Director 219-05-7390 Usual Residence of Decedent or 28a-f show 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 X No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7 SLADE AVENUE, 21208 USA items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ⚠ Yes 2 ☐ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. and Mental Hygiene. is marked other than "natural", or i 3 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed 3 ☐ Widowed 4 ☐ Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) **ATTORNEY** LAW Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည be f ABRAHAM SCHERR FANNIE KAPLAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shent of Health a SIMA SCHERR / WIFE SLADE AVENUE, #406, PIKESVILLE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or o BETHTE ENDER or other place) 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KURLAND CEM. 02/19/2010 BALTIMORE, MD re of Funeral Service Lic 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a Examin bunial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Pregnant at time of death 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a, Was an autonsy page death? 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Hospital 2 No ရု 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA 4 🖔 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural injury work? 5 Pending within 24 hours after death. To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, 000 31. Date filed (Month, State

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Registrar

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 9 Physician/ FEBRUARY STEINBERG 06:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3718 BARTWOOD ROAD BALTIMORE Social Security Number 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Months Days Hours Min. 0172071921 Director 212-20-9699 89 Yrs MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 🕅 Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3718 BARTWOOD ROAD 21215 USA 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural". 3 Midowed 4 ☐ Divorced WHITE Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **TEACHER** EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH 1 KOBIN FANNIE UNION 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BONNIE BERENGUER / DAUGHTER 3718 BARTWOOD ROAD, BALTIMORE, MD 21215 20a. Method of Disposition Page 1 a 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State MOSES MONTEFICRE WOODMOOR HEBREW 1 🕅 Burial 2 🗌 Cremation 3 🗌 Removal from State BALTIMORE, MD 4 Donation 5 Other (Specify) 2/19/2010 Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Matt 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner OVELLY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Dav 5 Other (specify) Year ed by the a detached f 2 🗌 No g Unknown 9 Unknown P.O. | signed by det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, To the Hospital or Attending Physician: The law requires the within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 IN Waventi 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မှ 1 Inpatient 2 Impatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

(Check only one) 29b. Signature an

30. Name and

2 didical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated did Certifying Nurse Plactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY SILAS M SCHWARTZ 2010 11:40 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 **X** M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours 6/22/1952 218-52-1421 57 Director MD Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💆 No MD HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10071 WINDSTREAM DRIVE, #6 21044 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ⚠ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by ☐ Yes 2 No Specify. Specify: WHITE "natural", 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) REVENUE EQUIPMENT SERVICEMAN TRANSIT AUTHORITY Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DANIEL SCHWARTZ DEBORAH RABINOWITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AMALIE BROWN/SISTER 39 DOLPHIN ROAD, NEWTON, MA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of HARNeter) Chilhatory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State TIFERETH ISRAEL CEM. 2/19/2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** THEINIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last the attending physician by Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy certificate has been signed by the atterirector, page 2 should be detached for in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Certificate: To Be Completed 1 🗌 Yes filled in by the funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? 1 Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 At Other (Specify 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) 1 🗷 Natural 5 Pending work? 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N CHARLES ST, SMITE 4105 BALTIMORE, MD 21204 DANIEUE BOBERMAN, MD 31. Date filed (Month, Day, Year) State FEB 22 Registrar

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Sattel, Hilda

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Baltimore,	permit. Page 1 and bepartment of Heali Important: If item 2 any injury or other once.		20a. Method of Disposition 1 A Burial 2 Cremation	3 ☐ Removal from State		Place of Dispo cemetery, cren	natory or	other plac		Date		Location - City of		
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. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 💆 No 9 ☐ Unknown	1 Live Birth	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)					V47.70	-	23d. Date of d Month	elivery Day Year	
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Divisi	tal or Atters after de al Directo ed in by the		3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi				eet, facto	ry, office			(Street a Town, Stat		ural Route Number,	
	the Hospi hin 24 hou the Funer npleted fill	Medical	(Check 2 Medical Exonly one) 3 Certifying	Physician: To the best of caminer: On the basis of ea Nurse Practioner: To the	xaminatio	n and/or invest	igation, in	n my opinio	n, death occu	rred at the time, dat	e and plac	e, and due to the	cause(s) and manner stat	ed.
	o Mit		29b. Signature and title of certifier					c. License			29d. Date signed (Month, Day, Year)			
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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 5 State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month Day 5 TURNER OZ /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death LUM WUM If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) al Security/Yumbe **Funeral** Days 1 M 2 K F Months Hours Min. Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at Director 1∡Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 11 Marital Status 14. Race - American Indian. 1 □Yes 2 X If Yes, Give Year or Dates: 1XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r any injury or other traumatic event, Item A once. College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signature 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mont **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director. After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknowi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 🗆 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Vithin 24 hours are To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Condition of the date and place and place and place and due to the cause(s) and due to the cause(s) and due to the cause(s). Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ane 1700

State Registrar 31. Date filed (Month)

Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ urver Month 2:00p Feb 6, 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A 1034 Marlau Drive Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 - F Months Days Hours Month, Day, Jun 11, 1935 Director Waryland 213-32-0219 Usual Residence of Decedent ral", or items 23a or 28a-f shov Ex miner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1034 Marlau Drive 21212 U.S.A within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married Yes, Give 2 No Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Black Completed 3 🗆 Widowed 4 🗆 Divorced Specify. Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) CSX Railroad Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gladys T. Banks Andrew Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 814 East 33rd Street Baltimore, Maryland 21218 Elsie P. Turner Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State injury or 1 Durial 2 🙀 Cremation 3 Demoval from State Catonsville, Maryland 02/22/10 4 Donation 5 Other (Specify) Metro Crematory, Inc. 21. Signa ure of Luneral or rvice Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. 300 Eutaw Place Baltimore, Md 21 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final nset and Death Ph, sician/ mon Medical resulting in death) Due to (or as a consequence of): **Examiner** quantially list conditions, Esquentiany list commons, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant 9 Unknown Pregnant at time of death Other (specify) Month Day Year detached g 🗌 Unknown P.O. signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 1 Yes 2 No Yes 2 completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

Signature and title of certifie

31. Date filed (Month, Day, Year)

M

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601

Hahh

29d. Date signed (Month, Day, Year)

			Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
			State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 2 0 0 4882
	Dhusisi		1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
	Physici /Medic	al	Mildred Merle Thomson February 18, 2010 4:00 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Examin	er	Masonic Home of Maryland Lutherville Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month), Day, Year)
i,	Director		286-24-7782 1 M 2X 91 Yrs. Months Days 10013 April 17,1918 Arkansas
	arylan show ed at	'n	10a. State
	r 28a-f notifie	irect	AD Charles Mushes
	ath with 23a o ust be	Funeral Director	300 International Circle Apt. 224 21030 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,
	ter dez Items Iner m	-une	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.
9036	ours at ral", or Exam	by	1 ☐ Yes Willowed 4 ☐ Divorced If Yes, Give Year or Dates: 1 ☐ Yes W☐ No Specify: Specify: White
15-0	n 72 h I "natu edlcal	letec	15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 54) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Oklahoma Public
212	d withi giene. er thar , the N	Completed	12 College (1-4or 5+) Teacher Schools
and	l be file ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last) Thomas Edward Rudell 18. Mother's Name (First, Middle, Maiden Surname) Olive Fuller
aryla	should nd Me mark umatic	으	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 0 3 0
, Z	and 2 ealth a m 27 is		Barbara Smith-daughter 601 Nicholas Lane-Cockeysville, Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition Date Commetter, Cramatory or other place Commetter, Cramatory or other pla
altir	permit. P Departme Importan any injur		21. Signature of Funeral Service Licensee 22. Name and Address of Facility
8	8 a E 6		Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234
	Dhysisian		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final
A. S.	/Medical	:	Immediate Cause (Final disease or condition resulting in death) a. Unit of the Denoriting Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Carelor Vascular Dusease
- 8	Examiner	<u>-</u>	Sequentially list conditions, If any leading to immediate b. Cerelly Vasular Dispose Due to (or as a consequence of):
	cuted d ansit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events conditions).
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Box	th cert tending or use a	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
P.O. E	the dea / the at ched fo	ysici	in the past 12 months? 1
	es that gned by	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ord	require ieen się hould k	ted !	CVA, HTIN, Hy peliproleura, no pite fay ternoz 1 Yes 2 No 3 Probably 4 Wunknown
Rec	he law e has t age 2 s	Completed	24a. Was an autopsy performed? death?
ital	ian: T	Be Co	25. Was case referred to medical examiner?
or V	Physic this ceral dire	ဥ	1 ☐ Yes 3 No
ion	inding ath. r: After re funer	ation	27. Manner of Death 1
Division or Vital Records,	or Atte fter de: Sirecto n by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Could not be determined 4 ☐ Homicide 4 ☐ Could not be determined 4 ☐ Homicide 4 ☐ Could not be determined 5 ☐ Could not be determined 6 ☐ Could not be determined 6 ☐ Could not be determined 7 ☐ City or Town, State)
	spital lours a neral C		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	N Viit	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
(ROBERT LIBERTO, W. 3108 Bach ST 21224
)	Sta Registr	ar	31. Date filed (Morte Bay Year) 32. Registrar's Signature 22. 2010 33. Registrar's Signature
T DH	MH 17 Rev 1/2	001	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February George William Timms 2010 9:20a м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stella Maris Baltimore Timonium Sex 1 M 2 □ F Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign (Month, Day, Ye Days Months Hours Director 196-28-3285 73 Tennessee 1936 Nov. Usual Residence of Decedent Show 10a, State 10c. City, Town or Location be filed within 72 hours after death with the Maryland must be notified at Director 10d. Inside City Limits 28a-f 1 ☐ Yes 2X No Harford Havre de Grace Maryland ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21078 3936 Deer Park Ct. USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify: Specify: White Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 8 Mason Masonary O Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John William Timms Emily Ward Page 1 and 2 should I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 3936 Deer Park Ct., Howard Timms (son) Havre de Grace, MD 21078 other Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State R.A. Ferris & Comp. 2/18/2010 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Acenses 22. Name and Address of Facility Cargo Funeral Home, P.A. Tarring-Ca land 21001or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ ESOPHAGEAL CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year 2 No 9 Unknown a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performe 2 🗆 No Yes 2 X No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 🗆 Yes 2 🗶 No Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

Records, Division of Vital

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9:20

2010

FEBRUARY 17

State Registrar

31. Date filed (Month, Day, Year) DHMH 17 Rev 7/2009

JACKIE JONES.

29a. Certifie

(Check

only one) 29b. Signature

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

2010

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registrar

32. Registrar's Signature

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}5, February 2010 Hobart Daniel Wolf, Jr. 8:01p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6134 Oklahoma Road Eldersburg Carrol1 8. Date of Birth (Month, Day, Ye July 14, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Year) 1924 Months Davs Hours 1 ☑ M 2 ☐ F 85 MN 220-14-3593 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore White Hall 1 ☐ Yes 2 X No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 21161 USA 2315 Hunter Mill Road 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: WWII White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Writer Journalism 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hobart Daniel Wolf. Sr. Katherine Herman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Patricia Welk Wolf (Wife) 2315 Hunter Mill Road, White Hall, MD 21161 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 2/17/2010 Sykesville, MD HATGHT FUNERAL HOME & CHAPEL, P PO Box 195 Sykesville, MD 21784 21. Signature of Funeral Service Licensee MGO PO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) saintially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No 9 Unknown 9 🗀 Unknown 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 A No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2 D 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 TYes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA avm 28d. Describe how injury occurred 28b. Time of

certificate be executed and burial-trar P.O. Box 68760, attending physician for use as the buria signed by the a of Vital Records, been has certificate or Attending Physician: this filled in by the funeral after death. Division

Physician

/Medical

Examiner

Funeral

Director

show

death with the

filed within 72 hours after

I Hygiene.

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, ITal ORCE.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

2

Examiner

Physician/Medical

Completed

Be

2

Certification:

Medical

29b. Signature and title of certifier

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medica examiner? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day,

32. Registrar's Signature

and manner stated.

ORIGINAL

29c. License number

5/2 Eldersburg MO

29d. Date signed (Month, Day, Year)

7,2010

within 24 hours a the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Joseph Wheeler, Sr. 3:45a Feb 10, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 2821 Kinsey Avenue If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Days Director 251-24-4613 Mar 30, 1924 So. Carolina Usual Residence of Decedent death with the Maryland 10b. County 10a. State show 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Madical Examiner must be notified at once. Director 1 Yes 2 No N/A **Baltimore** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 U.S.A 2821 Kinsey Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No þ Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) William Construction Co. Rigger 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillie Hudson Andrew Wheeler P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2821 Kinsey Avenue Baltimore, Maryland 21223 Queenie Wheeler 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/19/10 Lansdowne, Maryland 4 Donation 5 □ Other (Specify) Mt. Zion Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1 Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, ath. Approximate Interval Between nset and Death Immediate Cause I Inal **Physician** disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to minredule cause. Enter Underlying Cause (Disease or injury Examiner Directs (or as a nonsequence of): the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy jo Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) detached 1 ☐ Yes 2 ☐ No 9 Unknown n signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, ğ 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy this certificate 2 100 2 🗆 No 1 ☐ Yes 1 ☐ Yes or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 1∐ Yes 2 No 2 ER/Outpatient 3 DOA ٩ 1 Inpatient 5 Residence 6 □ Other (Specify) After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Natural 5 Pending investigation death. neral Director: A 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide hours Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 h To the Fur and manner stated and title of certifier 29b. Signature 29d. Date signed (Month, Day, Year) b 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201) MUA Chall 36.1 DN. 31. Date filed (Month, Day, 32. Registrar's Signature State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mildred Wolfe		1- For State Registrar	State of Maryla		partment of ertificate of		d Mental H		Reg. No.	201	0 0488		
Physicia Medical Exami		miliarea .	Belle W	olfe				2. Date of De Month February	Day 12, 201		3. Time of Death 1500 hrs		
		4a. Facility Name (if not institut 3217 Bert Koontz Ro		ımber)		4b. City, Town, or L Taneytown	Location of Deatl	h		County of De	eath		
Funeral Director		5. Social Security Number 219–12–2206	6. Sex	7. Age (In yrs. 86	. last birthday) Yrs	If Under 1 Year Months Days		n.		For	Birthplace (State or or or or or or or or or or or or or		
y		Usual Residence of Decedent						Aug.	30,	1923	Country) Maryland		
and show an	,	10a. State 10b. County Maryland	Carroll	110c. City	ty, Town or Locat		Vindsor				10d. Inside City Limits 1 X Yes 2 No		
Maryla or 28a-f	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What C	ountry?		
with the	rai D	405 Main S		cedent Ever in U	U.S. 13. Wa	2 as Decedent of Hisp	21776 panic Origin? (Si	necify Yes or N	No- 1-		, S . A nerican Indian, Black,		
a, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. teath and Mental Hygiene. teat 27 is marked other than "natural", or items 23a or 28a-f show any traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 N 3 Widowed 4 Di	Married Armed For 1 Yes	orces?	lf Y	es, specify Cuban, Yes 2 X No	Mexican, Puerto			White, etc			
2 hours "natur	sted b	15. Decedent's Education (Spe Elementary/Secondary (0-12)				nt's Usual Occupation ost of working life. [16b. Kin	nd of Busines	ss/Industry		
)036 within 7: iene. er than	Completed	11				seamstre	ess		se	ewing	factory		
21215-0036 Mond be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle				18	8.Mother's Name						
ID 2121 should be fi and Mental I is marked		William Da 19a. Informant's Name/Relation	Ship (Type, Print)		19b. Mailinç	Address (Street	and Number or I	ebra Rural Route Nu	imber, City	or Town, St	ate, Zip Code)		
	}	Dorothy Rue/ o	<u>daughter</u>	20b.		W. Baltim		Tane Date		n, MD	21787 or Town, State		
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Baltimore permit Pages 1 Department of 1 Important: If injury or other		21 Signature of Funeral Service		100 1	22. N	lame and Address o	of Facility Har	tzler F	Tunera	al Hom	ne e		
Physician	+	23a. Part I. Enter the disease, or	or complications that ca	aused the death	h. Do not enter th	10 Church ne mode of dying, si	uch as cardiac o	New Win	idsor, rrest, shock	MD 2 k, or heart	Approximate Interval		
/Medical	1	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Between Ons Death											
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Box 6876 e death certifica the attending ph ed for use as the	ΣI	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Uni	the 1 Live bir	ant at time of de	2 Feta	al death 3	Ectopic pregna	incy		Date of delive lonth	ery Day Year		
ires that the signed by the detache	ρ	Part II. Other significant condit	tions contributing to	death but not re	esulting in the ur	nderlying cause give	en in Part I.				to the cause of death?		
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed							24a. Was autop perfo 1 V Yes	psy ormed?				
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n of Vi	의	1 ✓ Yes 2 No 27. Manner of Death	28a. Date o	of Injury	ER/Outpatient 28b. Time of Inj			g Home 5	-	e 6 🗸 Oth	ier. Scene		
ivision of after death. Director: A lin by the fur	ertification:	Natural 5 Pend Pend Invest	ding estigation	Day,Year)			s 2 No			5			
Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	/ N L	4 Homicide deter	ermined (Specify)			t, factory, office buil		or Town, S	State)		Rural Route Number, City		
To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month.)												
	M	29b. Signature and title of certified		el m	250	29c, License n				te signed <i>(M</i> eary 13, 20	fonth, Day, Year) 010		
6	3	30. Name and address of person Victor Weedn MD JD	who completed cause Assistant Med			enn Street, Bal	Itimore, MD :	21201					
Sta Registr		31. Date filed (Month, Day, Year) FEB 2.2.201		gistrar's Signatu	ire	P							

Baltimore, Maryland 21215-0036

		1 - For State Registrar		-	•	e of Death	d Mental Hygie _{Reg}	NO 0 1 0	04888			
		1. Decedent's Name (First, Middle,	Last)				2. Date of Death Month	Day Year	3. Time of Death			
hysicia /Medic		Richard	Helm Well.	ing		02 18 2010 2:2						
xamin		4a. Facility Name (If not institution,	give street and number))	4b. City,	4b. City, Town, or Location of Death 4c. County of Death						
		Good Samaritan				ltimore						
neral ector		5. Social Security Number 212-36-1278 Usual Residence of Decedent	6. Sex 7. Ag	ge (In yrs. last birth	rs. If Under Months		in. (Month, Day, Y	ear) Co	thplace (State or Foreig Juntry) Maryland			
M T		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits			
200	ţō	Maryland Har:	ford	Ab	erdeen				1 □ Yes 2 ☑ N			
Total	Director	10e. Street and Number			10f. Zip	Code	10g	. Citizen of What Co	untry?			
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TIS	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	(Specify Yes or No- erto Rican, etc.)								
ning i		1 ☐ Never Married 2 ☐ Marrie	erto Rican, etc.)	Black, White	nite, etc.							
Exar	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2	! □XNo Specify:		Specify: W	nite			
lical	eted	15. Decedent's (Specify only highest	s Education	16a. [Decedent's Usua	l Occupation k done during most of v	uarkina 16	b. Kind of Business/	Industry			
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atic	Nevin L. Welling Lillie Mae Malone											
ranu		19a. Informant's Name/Relationshi		1	-		Rural Route Number, C					
Jer t		Toni Welling -	- wite				Aberdeen					
orot		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	3 ☐ Removal from State	cemetery	Disposition (Nam crematory or ot	her place)		c. Location - City or				
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imporant; it ten 2.1 is marked other than hatural, or items 2.3a of 28a-1 show any injury or other traumatic event, I've Madical Examiner must be notified at once.		21. Signature of Funeral Service Li	icensee		22. Name an	d Address of Facility E	ckhardt F	uneral (Chapel P.			
10 m		J. Harle El	Velo				r. Manche		Approximate			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
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sit	ine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or as	a conse uence of):							
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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran

Physici /Medi Exami

State Registrar

Medical Ce

29a. Certifier

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

RES 000

18/2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAFISA TAM 31. Date filed (Month, Day, Year) TAJIR 5601 Loch Raven Boulevard, Baltimore Maryland 21239

FEB 2 2 2010



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c, County of Death . Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 8. Date of Birth Funeral 1 ☑ M 2 ☐ F Months Hours Min Director Usual Residence of Decedent fshow iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give than "natural", 3 🗌 Widowed 4 🗆 Divorced Specify: Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Fig. al Service Lic. nsee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear, failure. List only one cause on each line. Immediate Cause (Final CANCER - metastatic Onset and Death Physician/ disease or condition resulting in death) Medical Examiner consequence of Sequentially list conditions, cause (Disease or iinjury Due to for ease nonelegienne of: Exam The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 2 🗌 No 9 Unknown 9 Unknown detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physician: funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 Residence 6 \square Other (Specify) 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖪 Natural work? 1 ☐ Yes 5 Pending 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year)
February 19, 2019 29c. License number

State
Registrar

DHMH 17 Rev 7/2009

N. Chales St. Balto. and 2020x

30. Name and address of person, who completed cause of death item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician YOUNG QUEEN 102010 February /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bon Secours Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 220-88-2560 **Director** Jan. 19,1963 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" or items 23a or 28a-f show any lipury or other traumatic event, I'm Incident Examination to the provider traumatic event, I'm Incident Examination to the provider event, I'm Incident Examination to the provider event, I'm Incident Examination to the provider event, I'm Incident Examination to the provider event, I'm Incident Examination to the provider event, I'm Incident Examination to the provider event, I'm Incident Examination to the provider event events. 10c. City, Town or Location 10d. Inside City Limits Director Y□Yes 2 □ No Maryland Baltimore 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 4819 Bowland Avenue 21206 USA Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 □Yes 2 No If Yes, Give Year or Dates: 1x Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. \$ Specify.Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Kovens Furniture Co. years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unk. Jessie Smith ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Thompson /Son 4819 Bowland Avenue Baltimore, Maryland21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 2/Green Mount Crematory 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore,Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licey e aris 5240 Reisterstown Rd Baltimore, 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

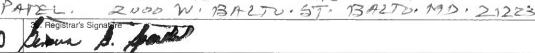
Immediate Cause (Final disease or condition resulting in death)

a. PNUEMON A Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner 24NG Sequentially list conditions, it is not less cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed OBSTRUCTIVE CKRONIC and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ KIDNEY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 No 1 ☐Yes 2 ☐No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural 1 ☐Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 T Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)
FEB 22 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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February 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Joan Marie Adams February 15, 2010 Physician/ 2155 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Prince Georges Southern Maryland Hospital Center Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** Age (In vrs. last birthday) Sept. 5, 1951 Days Hours 1 □ M 2 XX 58 217-58-3611 Marvland **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Knoxville Marvland Frederick 1 🗆 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21758 Funeral 1126 Rosemont Drive U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important; If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Coordinator Dentist Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Rosalita Young Richard David Jenkins, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1126 Rosemont Drive, Knoxville, MD 21758 19a. Informant's Name/Relationship (Type, Print) Ronald L. Adams, husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery Feb. 19, 2010 Frederick, MD 4 □ Donation 5 🛛 Other (Specify) Entombment 21. Signature of Keeney and Basford PA Funeral Home uperal pervice Lic M00255 106 East Church St. Frederick, MD 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury use as the burial-trans signed by the attending physician and deedeched for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{No} \) Day Month Year Pregnant at time of death 5 Other (specify) Unknown Part . Other significant conditions contylouting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ D 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s this certificate has performed? Yes 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Natural 28c. Injury at 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated for the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifyi 3 29b. Signature and title of 29d. Date signed (Month, Day, Year) 00 5512 person who completed cause of death (Item 23a) (Type, Print)

State Registrar 1325

OU

then avenue

SE Smite 310 WashinghonDc 20032

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Andrea Arce 347 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death If Under 24 Hrs. If Under 1 Year **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 环 F Months Days OI 22 Maryland Director na Usual Residence of Decedent 28a-f shov 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. iant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Fruitland 1 Tes 2 X No Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21826 USA 108 Moonglow Road ı "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 X Never Married 2 Married Yes, Gi 2 🗶 No Baltimore, Maryland 21215-0036 1 X Yes 2 → No Specify: Specify: 3 Widowed 4 Divorced Peru Peruvian Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) nlá n|a n|a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Sonia N. Valencia ည Roberto A. Arce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Moonglow Rd., Fruitland, MD 21826 Roberto Arcelfather 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Salisbury Crematory 1 28 10 Salisbury, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Name and Address of Facility
Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Extreme Onset and Death 25 werker Physician/ premaluri Medical Due to (or as a consequence of) Examiner Lespivator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate the Hospital or Attending Physician: hours after death.

neral Director: After this certific
d filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed : (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) 1)051310 22 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAlisbury CAPROLL St. 31. Date filed (Month, Day, Year) Registrar's Signatur State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma			rtment of F tificate of		d Mei		iene eg. Na	2010	04893
	Physici /Medic		1. Decedent's Name (First, Middle, Las Andrew Francis Act							Date of Death Month Druary		2010	3. Time of Death 09:15 A M
	Examin		4a. Facilify Name (If not institution, give 2815 Fennel Road	e street and number)	-		4b. City, Town, or Location of Death Edgewater 4c. County of Death Anne Arunde						
	Funeral Director		117 30 7022	ex 7. Age E M 2□F	(In yrs. last birth	day) rs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	in. 03	Date of Birth (Month, Day, 3/04/19			place (State or Foreign
	yland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Lo	cation						10d. Inside City Limits
	e Mar	cto	Maryland Anne Art	ınde1	Edg	ewa	ater						1 □Yes 2 □ No
	vith th	Dire	10e. Street and Number				10f. Zip Code	,				izen of What Cou	,
	eath v	Funeral Director	2815 Fennel Road	12. Was Decedent E	verin IIS T	13 \	21037		(Specifi			ted State	
9800	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fleem 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Medical Everning mult be notified at once.		1 Never Married A Married 3 Widowed 4 Divorced	Armed Forces? 1	0		Vas Decedent of H fYes, specify Cuba □Yes 2 X No	Specify:	erto Rica	an, etc.)		Black, White,	etc.
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Maryland	should and Me mark umartic	P_	19a. Informant's Name/Relationship (7		19b. N	Mailin	g Address (Street				City o	r Town. State. Zi	o Code)
, M	and 2 ealth a n 27 Is		Teresa L. Acton/Wi	fe	28:	15	Fennel R	oad, Ed	gewa	iter, M	D 2	21037	
Baltimore,	Pages 1 nent of H int: If iter iry or oth	1 9	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	20b. Place of D cemetery, Maryland	oispo: cren Vet	sition (Name of natory or other place erans Ceme	tery 02/	Date 08/2	"		cation - City or To $11e.$	own, State Maryland
Balti	permit. Departn Importa any inju		21. Signature is uperal Service bicen	the state of the s		22	Name and Addre	ss of Facility G	eorg	e P. K	ala	ıs Funera	al Home
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death. Do no							ewater.	MD 21037 Approximate Interval Between
n.	Physician		Immediate Cause (Final disease or condition	a ALA	nerall	24	File	ilur ce	,				Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a	onsequence of)	. /	1						
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68760,	eath certificate be executed attending physician and for use as the burial-transit	sal Ex	resulting in death) Last	Due to (or as a	consequence of)	:							
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rds, P	quires that the de	þ	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the	he un	derlying cause giv	en in Part I.			-		he cause of death?
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		BeC	25. Was case referred to medical examiner?					26. Place of D	eath (C		Mo)	1 □Yes	2 LIN0
<u>₹</u>	Physic this of al dire	ျှ	1 Yes 2 No		nt 2 ☐ ER/Outp			4 🗀 Nursing	Home	5 Resider	nce 6	6 ☐ Other (Speci	fy)
on (ding Phy h. After thi funeral	tion:	27. Mann of Death 1	28a. Date of Injur (Month, Day	y 28b. Tin Year) 1nju		28c. Injur Work M 1	yat ⟨? Yes 2 □ No	28d.	Describe how	w injury	y occurred	
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be determined	28e. Place of Inju building, etc.	ry - At home, farm (Specify)	n, stre		160 2 2 110	28f.	Location (Str. City or Town,	eet and State)	d Number or Run	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir.	edical C	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best of iner: On the basis of and manner state	examination and/	death or inv	occurred at the tir restigation, in my o	me, date and pla pinion, death oc	ace, and ccurred a	due to the ca	use(s) ite and	and manner as a place, and due t	stated. o the cause(s)
	To the vithin comp.	Me	29b. Signature and title of certifier	1/			29c. Licens	e number	<i>s</i>	29	d. Dat	e signed (Month,	Day, Year)
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(TILL		30. Name and address of person who o	completed cause of de	ath (Item 23a) (Ty	/pe, F	Print)	7 = 2 nd	An	us st.		way 7	
	Stal	ie	31. Date filed (Month, Day, Year)	32. Registra	's Signature	-	ROS,	760	11111	4101115	11.	11 21	70
	Registra	ar	FEB 03 20	170 Sener	e p.	1	acker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#1,per FH,QACHD,2/12/10,ms Certificate of Death Decedent's Name (First, Middle, Last)
 WAYNE 2. Date of Death Physician/ DONALD WILLIAM ANDERSON 11:20 AM **FEBRUARY** 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 510 ELM STREET STEVENSVILLE QUEEN ANNE'S Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 👿 M 2 🗆 F Months Days Hours MARCH I, Year) 28 **Director** INDIANA 218-24-0742 81 Usual Residence of Decedent show 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 X No MARYLAND QUEEN ANNE'S STEVENSVILLE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 510 ELM STREET 21666 UNITED STATES items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U. 2 No 1953 -14. Race - American Indian. Examiner Armed Forces?

1 X Yes 2 6 Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give 1956 "natural", 3 - Widowed 4 - Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) REAL ESTATE AGENT REAL ESTATE +4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FLOYD A. ANDERSON RUBY DURF WOODFIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 MAINBRACE DRIVE, QUEENSTOWN, MARYLAND 21658 GARY D. ANDERSON/SON 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State FEBRUÁRY 5. 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) STEVENSVILLE CEMETERY 2010 STEVENSVILLE, MARYLAND 21. Sig ur of Juneral Bervice License 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complication Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) CORONARY DISEASE Medical Due to (or as a consequence of): Examiner Sequentially list conditions. cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, Exam the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the buria Physician/Medical Box 68760 IE EEMALE. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 1 Live Birtin
4 Pregnant a
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year detached 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 X N certificate 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 잍 1 Inpatient 2 ER/Outpatient 3 DOA After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury s after death Accident Investigation 3
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 24 hours Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the within 2 only one 29b. Signature and the of 29c. License number 29d. Date signed (Month, Day, Year) D43080 FEBRUARY 4, 2010

State Registrar

parke

M.D., 1630 MAIN STREET, SUITE 208, CHESTER, MARYLAND 21619

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

MITCHELL B. SCHWARTZ,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2-15-2010 **Physician** RICHARD ALLEN BAXTER, SR. 3:15A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4574 SCOTTSDALE PLACE CHARLES WALDORF 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9 - 6 - 1 9 4 6 9. Birthplace (State or Foreign MD • 7. Age (In yrs. last birthday) Funeral 1 GM 2 □ F Months Days Hours Min. 217-44-5403 63 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MD. CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4574 SCOTTSDALE PLACE 20602 U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 XIYes 2 □ No USMC
IfYes, Give
Year or Dates: 1 9 70 - 72 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 □Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED CONSTRUCTION CONSULTANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROSE WEBSTER EDWARD CARSON BAXTER မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIRGINIA BAXTER-SPOUSE 4574 SCOTTSDALE PLACE WALDORF, MD. 20602 Department of Health Important; If Item 27 any injury or other tronge. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 M Cremation 3 Removal from State NETROPOLITAN CREMATORY 2-20-2010 ALEX., VA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00479 23a. Part 1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betwee 4006 Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examine If a y, Lading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diss to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Day Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1

Yes 2

No 3

Probably 4

Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred To the Hosphan ... within 24 hours after death.
To the Funeral Director: Aft 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and add D LINE LEWITH WACOE

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month SAIDE BERRY /Medical rebruare Facility Name (If not institution, give street and number Examiner City, Tow or Location of Death County of Death 979 At If Under 1 Year | If Under 24 Hrs 7. Age 8. Date of Birth (Month, Day, Year) 12-4-1929 5. Social Security Number (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months 1 □ M 2 🙀 F Days Hours POLAND 579-68-6729 80 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Director MD. CHARLES 1 ☐ Yes 2 ☐ No WALDORF 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 12150 MARBELLA COURT by Funeral 20601 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 1 □Yes 2√□ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: SpecifyWHITE 3 Widowed 4 ☐ Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than Elementary/Secondary (0-12) DEPT.OF NAVY College (1-4or 5+) ACCOUNTING TECHNICIAN U.S.GOVT. marked other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) YAHYA MELEKOGLU EMINE MELEKOGLU ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH VERAMENDI-DAUGHTER 10519 SUGARBERRY ST. altimore, WALDORF, MD. 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 6 M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any injury or TRINITY MEM.GARDENS 2-19-2010 WALDORF, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A. _M00479 PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Physician disease or condition resulting in death) minutes /Medical Due to (or as a consequence of): Examiner De Pendent Yea/s Inswin Seque itially liet our ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the burial-trans Due to (or as a consequence of) O. Box 68760 physician Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à hypertension dementia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed page 1 ☐ Yes 2 AN 1 ☐ Yes 2 ☐ No or Attending Physician; rector, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ⊈Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this 27. Mann T Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Onlin Lar V Sindhli) and 6 Post affice Rd. Suite 101 waldorf

Registrar DHMH 17 Rev 1/2001

State

FEB 22 2010

Physician

Examiner

Funeral

Director

show

Director

Funeral

2

Completed

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th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at

death

/Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Examiner Physician/Medical <u>۾</u> Completed Be Certification: To

State

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANEMIB autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D31875

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOWBROOK RD SUITE 450 CLUMPERLAND MD ZISÓZ

12502 WIL M.D

31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 22 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gladys Elizabeth Bartz Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Cumberland Allegany If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 5. Social Security Numbe Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** 1 M 2 DF Sep 10 Director 218-16-4046 85 Usual Residence of Decedent ar than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Allegany Cumberland 1 XYes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10301 Christie Road NE 21502 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify 3 XWidowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) laborer Celanese Co Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ George Bartz Rose (Kroll) Bartz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 2204 School Road Darlington MD 21034 Linda Ellis per. rep 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Restlawn Memorial Gardens 2/22/201b LaVale MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funcial Service Licensee 22. Name and Address of Facility ral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death MYOCARDIAL INFARCTION Ph sician/ ACUTE disease or condition resulting in death) Medical Due to (or as a consequence of): [≨]Examiner DISEASE CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death signed by the ar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Director: After this certificate 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 🔼 No 1 🗆 Yes 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending **™**Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D26907 FEBRUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

FEB 22 2010

32. Registrar

WALSH ROAD CLYMPEPLAND MP ZUSOZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per of Maryland 3 Gerarment of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Donald Blank Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Allegany WMHS-RMC Cumberland 5. Social Security Number 632 212-38-246 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Dec 3 . 19<u>39</u> 1 □**x**M 2 □ F **Director** 70 show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland n and Mental Hygiene. Director iral", or items 23a or 28a-f s Examiner must be notified Allegany Oldtown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21555 10400 Mertens Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give After 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Divorced 4 Divorced After 55 white Year or Dates er than "natura the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CSX Railroad Conductor marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Donna (Kellar) Blank Samuel Blank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code)

AND 21555 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum Shelvie Blank wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 1 Durial 2 Semation 3 Removal from State 2/14/2010 MD 4 ☐ Donation 5 ☐ Other (Specify) Cresaptown 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature 108 Virginia Avenue: Cumberland, MD 21502 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ship k, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Physician/ Medical resulting in death) Examiner corebrasila Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? Month 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 21100 |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 1 Certifying Physician: To the best of my nowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29c. License number 166 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 04900 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ A M February Dolores Fetsko Bailey 2010 0950 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital Ceci1 E1kton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 ី F Months Director 150-20-7863 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County ral", or Items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Completed by Funeral Director 1 🗌 Yes 2 🏋 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 114 Spears Hill Road 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married "natural", or Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Circuit Court Clerk</u> County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Michael Fetsko Julie Chapko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Karen B. Connell/Daughter 112 Spears Hill Road, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) February St. Augustine 4 Donation 5 Other (Specify) 18. 2010 Chesapeake City. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic botrective Pulmonary Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box ☐ Ectopic pregnancy in the past 12 moviths?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day 5 Other (specify) Year ed by the a 9 Unknown P.O. cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p. 25. Was case referred to medical 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Hospital or Attending P
 24 hours after death.
 Funeral Director: After the Certificate: 28d. Describe how injury occurred ✓ Natural 5 Pending work? 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2,16 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tuff Sr Elk Con MD 21921 31. Date filed (Month, Day, Year, State Registrar

enneth Allan B		De St 1- For State	ate of Maryla	and / Depa		f Health and		Hygiene	21	010	04901
Physici Medical Exami	an/	Registrar 1. Decedent's Name (First, Midd KENNETH	le,Last) ALLAN BR					2. Date of De Month February		Year	3. Time of Death 1015 hrs
*		4a. Facility Name (if not institution 300 Block Main Street		umber)		4b. City, Town, or Elkton	Location of De			nty of Death	
Funeral Director		5. Social Security Number 222–34–4108	6. Sex	7. Age (In yrs. I	-	Months Days		Min	irth(MM/DD/Y /16/195	Foreig	hplace (State or n untryMARYLAND
Varyland 28a-f show any 1 at once.	tor		W CASTLE	10c. City	, Town or Locat	NEWAR	KK		-		10d. Inside City Limits 1 X Yes 2 No
h the Mary 3a or 28a otified at	Dire	10e. Street and Number 126 MADIS	ON DRIVE			10f. Zip Code	111		10g. Citizen of What Coun UNITED S'		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	3 Widowed 4 Div	larried Armed F 1 Yes vorced If Yes, Give Yes or Dates:	2. No ar	1	es, specify Cuban Yes 2 X No	, Mexican, Pue specify:		Spec	White, etc. $_{\it ify:}$ $^{\rm B}$	can Indian, Black,
0036 within 72 hours gene. ner than "natu Medical Exam	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12	College (during m	it's Usual Occupatiost of working life.	DO NOT use	retired)	WAS		NAGEMENT
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To the Hos within 24 h To the Fun	Medical	one) 2 Medical Exa 29b. Signature and title of certifie	miner: On the basis and manner s	of examination a tated	nd/or investigat	ion, in my opinion, 29c. License		ed at the time, date			th, Day, Year)
		30. Name and address of person	who completed caus	se of death (Item	1 23a)	O.C.M	Л.Е .		February	5, 2010	
i.j	ate	Pamela E. Southall, N 31 Date filed (Month, Day, Year)		Medical Exa		1 Penn Street	, Baltimore	e, MD 21201	**		-
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			For State Registrar	Sta	ate of M	arylan		artment tificate			ınd M	ental Hy	giene	0 0	0490	12
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	Funeral		5. Social Security Number	6. Sex		ge (In yrs.	last birthday)	If Under	1 Year	If Under a		8. Date of Bir	th	9. Birth	place (State or	Foreign
	Director		137-14-6757	1 □ M 2	8 (6	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 6 - 25 -	1923	MD	intry)	
			Usual Residence of Decedent			,										
	ytan how		10a. State 10b. County			10c. Cit	y, Town or Lo	cation							10d. Inside Cit	
	Ma -1-	ţ	MD Wicom	ico		Sal	isbur	У							1 (X Yes	2 No
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Ω.	deat e atte	cla	in the past 12 months? 1 □ Yes 2 ☑ No	4	☐Pregnant a			Other (sp						Month	Day Y	'ear
	t the by th ache	Physician/Med	9 🗆 Unknown	91	Unknown											
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ō	Phy r this	 -	27. Manner of Death	28	a. Date of Inj	ury	28b. Time o		8c. Injun	y at		28d. Describe			ary)	
	ding h. Afte	ţļ	1 Natural 5 Pendin 2 Accident investig	g	(Month, Da	ay Year)	Injury	м	Worl	k? Yes 2 □	No					
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2	after after Dire	Certification:	4 Homicide	illed	building, e							City or To	wn, State)			
	spita lours herai		29a. Certifier 1 Certifyin	g Physiciar	n: To the best	t of my kno	owledge, deat	h occurred	at the tin	ne, date ar	nd place,	and due to the	cause(s) a	nd manner as	stated.	
	To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death. To the Funeral Director, there this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical	Evaminer (on the bacie	of avamina	tion and/or in	voctiontion	io my o	ninian das	th occurr	ad at the time	date and n	lace and due	to the causals	1
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1	1001	1	30. Name and address of person	who comple	ted cause of	death (Iter	n 23a) (Type	Print)			4		4 3	7 14:	6 7,	
	DN		Babulal Das. 1	10.1	06 Mc	elvi	d st	#5	041	3,5	solv	siny	MI	218	14	
*	Sta	ite	31. Date filed (Month, Day, Year)		32. Aegist	trar's Signa	atuse /	a. W. J								
	Registr		29b. Signature and title of certifie 30. Name and address of person Ballular Day, Year) FEB 0 4	2010	Dane	w ,	p. 49	wer.								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Betty Catherine Barker February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital of Cecil Elkton Cecil If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth Nov. 17, 1926 9. Birthplace (State or Foreign Funeral 1 M 2 X F Country) Maryland Director 219-20-7538 83 Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Maryland Cecil Conowingo 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21918 U.S.A. 168 Conowingo Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. "natural", or þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Ten Years College (1-4 or 5+) Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Stephen Jones Iva Culley other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia J. Barker (daughter) 100 Revolution Street, Havre de Grace, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
R.A. Ferris & Co., Inc. 20c. Location - City or Town, State West Chester, 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or 02/09/10 Pennsylvania Lee A. Patterson & Son Funeral Home, P Perryville, <u>Marvland</u> 21903-0766 21. Signature of Funeral Service Licenses pmass Perryville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months' Month Day Pregnant at time of death Year 1 Yes 2 9 Unknown the i detached 9 Unknown P.O. ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ pe Division of Vital Records, 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been six completed filled in by the funeral director, page 2 should to Completed 1 Yes 24b Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

and address of person who completed cause of death (Item 23a) (Type, Print) ATE

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Phy Sician : bond, cilbert Pacil Physician/ Month GILBERT CECIL BOND, SR 9:55 PM february 2010 Medical 4a. Facilify Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PERRY toing Ceci A MARYLAND HEALTH CARESYSEM Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9 Birthplace (State or Foreign ^{Yea}r) 934 1 X M 2 □ F Months Hours Min. JULY 28 Director 216-30-5076 75 MARYLAND Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified MARYLAND HARFORD 1 X Yes 2 No **ABERDEEN** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21 ROOSEVELT AVENUE, APT H2 21001 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: BLACK 3 ¥ Widowed 4 ☐ Divorced Year or Dates. 1952-56 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 0+ 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) RECREATIONAL SUPERVISOR JUVENILE SERVICES KNOWN Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ should be NORVEL BOND ISABELLA REBECCA THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA JACKSON / DAUGHTER 1909 BELL FLOWER COURT, EDGEWOOD, MARYLAND 21040 Page 1 and 2 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) AME Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State GARRISON FOREST VETS 02/17/10 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility LISA SCOTT FUNERAL HOME, P. 552 LEWIS STREET, HAVRE DE Vott Colo MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PAncreati JUKNOWIN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed sician and burial-trans that initiated events 10 Due to (or as a consequence of) resulting in death) Last the attending physician the for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month 4 ☐ Pregnant a 9 ☐ Unknown Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this continue. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 **5** No မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) HOS () CE 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D57239 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HTIVA ShandelyA REARY POINT MD 21902 uresh M.D., VAMARY CAND HEALTH CANE SYSTEM 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

		1 - For State Registrar	State of Maryla	nd / Dep	artmei		th and l	Re	iene201	0 04905
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Maryland a-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Frederic	_	City, Town or L						10d. Inside City Limits 1 Tyes No
h with the 23a or 28	ai Director	10e. Street and Number 3200 Baker Circle	2		10f. Zi	21710)	1	0g. Citizen of What USA	t Country?
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Maryland 21215-0035 d 2 should be lifed within 72 hours aff th and Mental Hygiene. 27 is marked other then "netural", or traumalic event, the Medical Exami	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	kind of w	ual Occupation ork done during use retired)	most of wo	rking	Own h	
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Physiciar /Medica Examine	1	23a. Part1. Piter the disease, or company of the art failure. List only immediate Cause (Final disease or condition resulting in death)	olications that caused the decone cause on each line. Plasmo	ath. Do not en	ter the mo					Approximate Interval Between Onset and Death
te be executed ysicien and burial-transit	icai Examiner	Sequentially list conditions, In y, learn y to a misdist or cause. Enter Underlying cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consi Due to (or as a consi d.							
law requires that the death certifica es been signed by the attending phose should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3[⊒Ectopic p ⊒ Other (s				23d. Date of Month	delivery Day Year
ecords, F. law requires that es been signed by 2 should be deta	þ	Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	ınderlying	cause given in i	Part I.			te to the cause of death? Probably 4 Unknown
The The page	Completed							24a. Was an autops perform	ned? deat	e autopsy findings available to completion of cause of h? Yes 2 □ No
OI VICAL Physicien: Tribis certificet	To Be	1 165 2/5/140		☐ ER/Outpatie		OA Other: 4	A STATE OF THE STA	th Check only on ome 5 ☐ Reside	700	Specify)
	ation:	27. Manner of Death 1 Sonatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of M	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe ho	w injury occurred	
	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Spe	cify)				City or Town	, State)	r Rural Route Number,
To the Hospital or within 24 hours eft To the Funeral Discompletely filled in	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my k liner: On the basis of exami and manner stated.	nowledge, deal nation and/or in	th occurred evestigation	at the time, da n, in my opinion	te and place , death occu	, and due to the ca rred at the time, da	use(s) and manne ite and place, and	r as stated. due to the cause(s)
To the I within 2 To the Complet	Me	29b. Signature and little of certifier	mo		29	c. License num		29	od. Date signed (M	
		30. Name and address of person who d	completed cause of death (It				e Wa	rren	2-4	-10
8	tate	3000 - D Ventri 31. Date filed (Month, Day Year)	20. De sistemble Cie	nature /	mo	21773				
Regis		FER ()	1. 20 11 Lener	us B.	1400	aper				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **Blank** February 2°, 2010° 7:20 PM M Pauline Ellen Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Frederick Frederick 7819 Old Receiver Road Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) Days 1 □ M 2 🔽 F 220-16-2241 85 Marvland **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items "" any injury or other traumatic 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🖺 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 7819 Old Receiver Road 2**17**02 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐XNo If Yes, Give 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lilly Linton Carl May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7819 Old Receiver Road, Frederick, MD 21702 Milton M. Blank, husband 20b. Place of Disposition (Name of cemetery, crematory or other place)

Rocky Springs Cemetery Feb. 5, 2010 20a. Method of Disposition 20c. Location - City or Town, State XXurial 2 Cremation 3 Removal from State Frederick, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Keeney and Bastord PA Funeral Home 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1e+as+aze Physician/ Conter disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🔲 No 2 Ves 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 \subseteq Yes Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending 2 🗆 No 1 Tyes Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johnson Dr. MD 31. Date filed (Month, Day Hemen State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Facility Name (If not institute FROSTBURG VII Social Security Number 232-07-2142 sual Residence of Decedent a. State 10b. Count MD AI e. Street and Number 58 LAVALE COU. Marital Status 1 Never Married 2X M. 3 Widowed 4 Divorce 15. Deceded.	BRIEN CALAI ion, give street and numbe LAGE NURSING 6. Sex 1 M 2 F 7. A ty LEGANY JLEGANY 12. Was Deceder Armed Forces 1 Mes 2 F if Yes, Give Year or Dates ent's Education hest grade completed)	F) G HOME Age (In yrs. Ia: 92 10c. City, LA	Yrs. Town or Loc AVALE	FROSTE If Under 1 Year Months Days cation 10f. Zip Code 21502 Was Decedent of H	If Under 24 Hrs. Hours Min.	2. Date of Dea Month 02 8. Date of Birt (Month, Day 08/10/	Day 2 20 4c. County of ALL. h, Year) 1917	9. Birthpla Counti NEST	ace (State or Fory) VIRGINI vd. Inside City Li 1 □ Yes 2 ∑	
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Elementary/Secondary (0-12		rade completed) (G			ation during most of work	ing.	16b. Kind of Bus	iness/Indu	ustry	
7. Father's Name (First, Middl	-	r 5+)	life. L	DO NOT use retired	d)	rig				
. Father's Name (First, Middi	(a. / aat)		ACCOU	NTANT/BOO	OKKEEPER 18. Mother's Name	/First Middle	BANK Maidan Surnama			
TITTE TARK CRATCH							waiden Surnamê	,		
WILLIAM SMITH 9a. Informant's Name/Relatio	-		19h Mailin	ng Address (Street	ALICE I	HEVENER	er City or Town	tate Zin i	Code)	
		1674		•					2300/	
Da. Method of Disposition	DKIEN / MEET								vn, State	
		eı				7/2010	Γ.ΔVΔΤ.	E. MT)	
21. Signature of Funeral Service Licensee // / A-Paragraph Address of Facility SERVICE, P.A.										
Ho no	D. Trock	wel		1302 NAT	CIONAL HI	GHWAY, I	LAVALE,	MD 2	21502	
Sequentially list conditions, if any, Leading to inmodulat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):										
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknowh	1 ☐ Live birth 4 ☐ Pregnan	у			ry Day Ye					
art II. Other significant cond	itions contributing to death	but not resul	ting in the ur	nderlying cause give	en in Part I.					
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	cal				26. Place of Deat			⊔ Yes	2 LIN0	
examiner? 1 ☐ Yes 2 ☐ No	Hospital:	atient 2 🗆 E	R/Outpatier	nt 3 DOA Oth	er: t_			r (Specify)	
7. Manner of Death		njury Day, Year)	28b. Time of Injury	Worl	y at /	28d. Describe h	now injury occurre	d		
2 Accident inver	stigation Id not be 28e. Place of	Injury - At hor	me, farm, str		Yes 2 □No	28f. Location (S	Street and Number	r or Rural	Route Numb	
4 Hornicide	Dunding,			th occurred at the ti	me, date and place			nner as st	tated.	
(Check only 2 Medic one)	ai Examiner: On the basis and manner	s of examinati stated.	ion and/or in	nvestigation, in my o	opinion, death occur	red at the time,	date and place, a	nd due to	the cause(s)	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month								(Month, E	Jay, Year)	
Them, D 26907 FEBICUTTY								7 1	2,201	
). Name and address of person	on who completed cause o	f death (Item	23a) (Type	Print)	Intal Ro	1 000	buchn	1 00	17 11	
1 S rie etasas 7	a. Method of Disposition 1 Burial 2 Crematio 4 Donation SCOther 1. Signature of Funeral Service 3a. Part 1. Enter the Lease, shock, or heart failure. Lease, shock, or heart failure. Lease, shock, or heart failure. Lease or condition is ulting in death) and the sease or conditions, and the conditions is ulting in death. FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown and II. Other significant conditions in the past 12 months? 1 Yes 2 No 9 Unknown 3 Suicide Accident inverse in the past 12 months? 4 Homicide Geter inverse	a. Method of Disposition 1	a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation	a. Method of Disposition Burial 2 Cremation 3 Removal from State	a. Method of Disposition	All Method of Disposition 1	a. Method of Disposition Burlal 2 Cremation 3 Removal from State All Donation XXOther (Specify) Transment RESTLAWN MEML GARDENS O2/17/2010 Signature of Funeral Service Licensee RESTLAWN MEML GARDENS O2/17/2010 Signature of Funeral Service Licensee RESTLAWN MEML GARDENS O2/17/2010 Signature of Funeral Service Licensee RESTLAWN MEML GARDENS O2/17/2010 Signature of Funeral Service Licensee RESTLAWN MEML GARDENS O2/17/2010 Signature of Funeral Service Licensee RESTLAWN MEML GARDENS O2/17/2010 Signature of Funeral Service Licensee RESTLAWN MEML GARDENS O2/17/2010 Signature of Funeral Service Licensee RESTLAWN MEML GARDENS O2/17/2010 Signature of Funeral Service Licensee RESTLAWN MEML GARDENS O2/17/2010 Signature of Funeral Service Licensee RESTLAWN MEML GARDENS O2/17/2010 Signature of Funeral Service Licensee RESTLAWN MEML GARDENS O2/17/2010 Signature of Funeral Service Licensee RESTLAWN MEML GARDENS O2/17/2010 Signature of Funeral Service Licensee RESTLAWN MEML GARDENS O2/17/2010 Signature of Funeral Service Licensee RESTLAWN MEML GARDENS O2/17/2010 Signature of Funeral Service Licensee RESTLAWN MEML GARDENS O2/17/2010 Signature of Funeral Service Licensee RESTLAWN MEML GARDENS O2/17/2010 Signature of Funeral Service Licensee RESTLAWN MEML GARDENS Service I Gardensee of Garde	a. Method of Disposition Burial 2 Cremation 3 Removal from State	a. Method of Disposition Date 20c. Location - City or Tow Burial 2 Coremation 3 Removal from State 4 Donation 3 Removal from State 20c. Location City or Tow 22 MATHER STOMERT SerVICE, LAVALE, MD 23. PArt Earth the Life asso, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. PART Earth the Life asso, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. PART Earth the Life asso, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. PART Earth the Life asso, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. PART Earth the Life asso, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. PART Earth the Life asso, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock orespiratory arrest, shock or respiratory arrest, shock or respirat	

DHMH 17 Rev 1/2001

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State

Registrar

Name and address of person who completed cause of death (Item 23a)
 Ling Li, MD Assistant Medical Examiner 111 Per

2010

32. Registrar

OCME

111 Penn Street, Baltimore, MD 21201

February 14, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death p Physician/ Month 50 M William Clayton Calloway -conum 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death . 54/156410 REGIONAL VICIMICO Teninsum Social Security Number . Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth **Funeral** (Month, Day, July 13 1 2 M 2 D F Days Min. Director 221-05-6764 89 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or pother traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No DE Delmar Sussex 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 707 Jewell Street 19940 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 🖾 Yes 2 🗌 No 1943þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: 3 Widowed 4 Divorced Completed 1945 white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Postmaster Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marion H. Calloway, Sr. Susie Hastings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne D. Calloway 707 Jewell Street Delmar, DE 19940 (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9, 2010 Delmar, Delaware Stephens CemeteryFeb. . Signature of Funeral Service Licenses 22. Name and Address of Facility
Short Funeral Home
13 East Grove Street Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, porumano disease or condition Capiration Medical resulting in death) Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit 75CM Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death Ves 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? bleed 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: မြ 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) N of person who completed cause of death (Item 23a) (Type, Print) ن. ک 100

DHMH 17 Rev 7/2009

State Registrar Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** DeHaven Alice Cora /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Allegany 12910 Growndenvale Drive Cumberland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth . 1919 **Funeral** Months Days Jul 19, 1 □ M 2 □ ₹ 234-42-9238 90 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be natified at Cumberland MD Allegany 1 □ ¥es 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 12910 Growndenvale Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ 📉 Specify: Specify: Completed by white 3 □XVidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Holiday Inn supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nathaniel M. Wilkins .Sr. Cora B. (Wilson) Wilkins ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) MD 21502 Cumberland Dorothy Appel daughter 1002 Michigan Avenue 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 2/12/2010 WV Olivet Cemetery Moorefield 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral 3 Price Licensee 22. Name and Address of Eacility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician condum disease or condition resulting in death) je. /Medical Due to (or as a consequence): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending hybrarian and attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) $\,$ neral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached in 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perforn 1 ☐Yes 2 ☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cert BLOTGLO

State Registrar

istrar FEB 22 2010

RONAL M.D. 924 SETON DRIVE CUMBERLAND MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ebra J. Duckw	orth	1- For State Registrar	ate of Maryla		artment o ertificate of		l Mental		Reg. No. 20	0 0491
Physici Medical Exam		Decedent's Name (First, Middle)	Jean (Gray)	Duckw	orth		2. Date of De Month February	ath Day Year	3. Time of Death 1505 hrs
		4a. Facility Name (if not institution Western Maryland Re	on, give street and nur	mber)		4b. City, Town, or L Allegany	ocation of Dea		4c. County of D	eath
Funeral		Social Security Number		7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24		irth (MM/DD/YYYY) 9	
Director		218-60-1415	1 M 2 X F	56	Yrs	Months Days	Hours N	Feb	10, 1953 🖺	Country)
nd show any nce.	'n	Usual Residence of Decedent 10a. State PA 10b. County B	Sedford	10c. City	, Town or Locat Hyr	on ndman				10d. Inside City Limits 1 X Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number P.O. Box 433	3			10f. Zip Code	1554		10g. Citizen of What (Country?
th with the	Funeral D	11. Marital Status	12. Was Dece	edent Ever in U		s Decedent of Hisp es, specify Cuban,	anic Origin? (Specify Yes or N		merican Indian, Black,
s after deat rral", or ite	ģ	3 Widowed 4 X Div	1 Yes orced If Yes, Give Year or Dates:	2 X No	1	Yes 2 X No	specify:		Specify: V	vhite
036 thin 72 hour ne. r than "natu	The Constraint of the Mary Special Research o					t's Usual Occupationst of working life. I		16b. Kind of Busine	k's Restaurant	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	Be Cor	17. Father's Name (First, Middle, Charles G	ray	· · ·		18			Maiden Surname)	
nore, MD 2121 signs I and 2 should be fit it of Health and Mental it. If item 27 is marked other traumatic event,	To	19a. Informant's Name/Relations Terri Dabbs	nip (Type, Print)	daught	ter 9	Address (Street Vestview	and Number of Terrac	e C	imber, City or Town, S umberland	tate, Zip Code) MD 21502
rre, les land freels fr		20a. Method of Disposition 1 Burial 2 Cremation		m State	crematory or oth			Date 2/13/20	20c. Location - City	y or Town, State Aptown MC
Baltimore, permit. Pages I at Department of Het Important: If ite injury or other tr		4 Donation 5 Other Sp 21. Signature of Funeral Service		S		uneral Home	elli Puhera		\	
Physician		23a/Part/1. Enter the disease, or	complications that ca	used the death	n. Do not enter th		_		perland, MD 21strest, shock, or heart	Approximate Interval
/M i I Examiner	1	failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	a. Fentan		xicatio	n				Between Onset and Death
*	L	Sequentially list conditions,	Due to (or as a d							
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a c							
and and transit		events resulting in death) Last	Due to (or as a d							
50, te be execut ysician and	fedical	X UNPENDED IF FEMALE:	AMENDED 23	a,PII,2	27,28a-f	,permE,	3900 2/	<u>/</u> 23/10 T	T	
lox 6876 leath certificate attending phy for use as the b	siciai	23b. Was decedent pregnant in th past 12 months? 1 Yes 2 No 9 ✔ Unk	e 1 Live bir	rth ant at time of de	2 Fet	al death 3 ener (Specify)	Ectopic preg		23d. Date of deli Month	Day Year
O. Bc at the des	Ph	Part II. Other significant conditi	a Olikilov		esulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use contribute	to the cause of death?
S, P.O. puires that the signed by Id be detach	ed by	<u> Hypertensive</u>	atherosc	<u>lerotic</u>	cardio	vascular	diseas	25		Probably 4 V Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Completed									e autopsy findings available to completion of cause of 1? Yes 2 No
Vital Rec ysician: The his certificate director, page	o Be (25. Was case referred to medical examiner?	Mary State	patient 2	ER/Outpatient		f Death (Chec	k only one) sing Home 5	Residence 6 0	ther:
ion of V tending Phy cath. or: After th the funeral d	-1	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi	28a. Date or (Month, I	of Injury Day,Year)	28b. Time of Ir	ijury 28c. Injury			how injury occurred	and .
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 X Could	tigation		ome, farm, stree	t, factory, office bui	lding, etc.	28f. Location (or Town, S Hyndma:		Rural Route Number, City d AVe
To the Hosp within 24 hou To the Funer completely fi	Medical C	29a. Certifier 1 Certifying Ph	niner:On the basis of	examination a				nd due to the cau	se(s) and manner as s and place, and due to	
5 ± ½ 5 8	Me	29b. Signature and title of certifier	and manner sta	ited.	\	29c. License O.C.M		Out. p	29d. Date signed (
	ł	30. Name and address of person	//	,	,	111 Page Ct	ot Delater	MD 0400		
St	ate	Theodore M. King, Jr., 31 Date filed (Month, Day, Year)	32 Reg	istrar's Signatu	ıre _	111 Penn Stre	et, Baltimo	ore, MD 2120	<u> </u>	
Regist	rar	FEB 22 2011	1 / harra		how the	7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 26 per DVR G900 2/22/10 dk.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 01:40 AM 2010 JAMON ANTONIO /Medical 4b. City, Town, or Locaus.

Baltimore

If Under 1 Year If Under 24 Hrs.

Anths Days Hours Min. 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Himore HOSPITA 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** Year) 1**□**M 2□ F Known Yrs Director -2010 Mary land Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "hatural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evaminer must be notified at Baltimore 1 Nes 2 No Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number SA 396 3 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Black Specify ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -Ntant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN tredricka ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3963 Red Dear Circle , Randallstown, mg 21133 Zitafa Fredricka Davidson (Mothed 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3 4 □ Donation 5 BOther (Specify) HospitaL HOSPITAL 10 22. Name and Address of Facility 5, NR 21. Signature of Funeral Service Licensee DISPOSAL Hospital 2401 W. Belocoere Ave Bal MD 21215 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SCLSAS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner abyup Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed PPYON To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P. O. 9 HInknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 対 No To the Hospital or Attending Physician: The Within 24 hours after death.

To the Funeral Director: After this certificate ha 1 □Yes 2 🗷 No 2 🛣 No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ∐Yes 2 Mo 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10110022 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's signature 31. Date filed (Month, Day, Year) State 22 Registrar

Baby

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amended itemes 19a&19b, SU, WCH Dertificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2010 Josephine Jane Daniels Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ninsul 8. Date of Bilth (Month, Day, Year) 2 – 21 – 1946 If Under 24 H 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Min. Months Hours Country) Director 219-46-4623 63 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No Snow Hill MD Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21863 4243 Spire Ct. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2X No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married 2 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: Black "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Worcester County life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Development Ctr Caregiver/Aide other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Thomas Spence, Sr. Esther Waters 1 and 2 should be of Health and Me fitem 27 is mark 4904Mailing Address (Street and Suppler on Raral Round Humber 818 g Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Oscar Daniels Sr., Husband 10409 Allens Mill Rd, Delmar, DE 19940 Devene Spence/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or of 1 XBurial 2 Cremation 3 Removal from State 2-5-2010 Calvary Pent Ch 4 Donation 5 Other (Specify) Bishopville, MD 22. Name and Address of Facil Bennie Smith h^{cility}917 W. Isabella St. Bennie Salisbury, Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final CUR Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Endmentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death ed by the 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be de þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 ☐ Yes 2 ☑ No Yes 2 No Division of Vital 25. Was case referred to predical æ 26. Place of Death (Check only one) examiner? Other: 2 12 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending work' 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title

State

Registrar

egistrar's Signature

FASTERN SAURE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB 04

1	State of Maryland / Department of Health and Mental State Registrar State of Maryland / Department of Health and Mental Certificate of Death	Reg. N		01.01
1	Decedent's Name (First, Middle, Last) 2. Date of Month		Day Year 3 2010	3. Firme of Death
r (a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death La Plata Social Secrets Number 6 Sex 7 App (In yes lest hirthday) If Under 1 Year If Under 24 Hrs. 8 Date	of Birth	Charle 9. Birth	n 25 nplace (State or Foreig Intry) th Carolin
-	0a. State 10b. County 10c. City, Town or Location			10d. Inside City Limit
II DILECTO				
by Funera	1. Marital Status 1. Marital Status 1. Marital Status 1. Marital Status 1. Marital Status 1. Marital Status 1. Marital Status 1. Mas Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 1. Mas Decedent of Hispanic Origin? (Specify Yes.) or No-	14. Race - Amer Black, White Specify:		
mpiereu	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) A cant			
å	7. Father's Name (First, Middle, Last) 18. Mother's Name (First, M	iddle, Maid	den Surname)	
ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	20c.	. Location - City or	Town, State
	21. Signature of Funeral Service Licenses M00945 AREHART CECHOLS FUNERAL 211 St. Mary's Ave. La	Plat	a,MD 206	546
dical Examiner	Due to (or as a consequence of): Due to (or as a consequence of):			
Physician/Med			23d. Date of de Month	livery Day Year
፭	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Did tobac	. /	o the cause of death robably 4 Unkn
Completed	1	autopsy performed Yes 2	dr? prior to death?	utopsy findings availa completion of cause s 2 □ No
ation: To Be	examiner? 1 Yes 2 No	Residence		ecify)
<u>õ</u>	3 Suicide 6 Could not be 28e Place of Injury - At home, farm, street, factory, office 28f, Loca	tion (Stree or Town, S	et and Number or R State)	ural Route Number,
ledical Certif	29a. Certifier 1 Certifying Physician: e best of my knowledge, death occurred at the time, date and place, and due			1.1.1
De Commission Internation Promised Promised Promised Promised Internation	De Completed by Priysicial/Medical Examining	1. Decedent's Name (Frat. Middle, Last) 2. Donohue 2. Make 4. Facility Name (if not institution, give street and number) 4. Donohue 4. D	1. Decedent's Name (Final, Middle, Last) 1. Donohue 2. Oate of Death 2. Oate of Death 2. A Facility Name (It not institution, give street and number) 2. Special Security Name of the other statution, give street and number) 2. Special Security Name of the other statution, give street and number) 2. Special Security Name of the other statution, give street and number 2. Special Security Name of Decedent curity me of Decedent Security Name of Decedent Security Name of Security Name of Decedent Security Name of Security Name of Decedent Security Name of Security Name of Decedent Security Name of Security Name of Nam	1. December Name (First, Middle, Leat) 2. Date of Death Month Processing Control of Section (Section Process) 3. Donohue 4. City, Town, or Location of Death Month Process (Section Section Name) 4. City, Town, or Location of Death (C. Courty of Death Month Process) 4. Courty of Death Courty of Death (C. Courty of Death Month Process) 4. Courty of Death Month Process (Section Name) 4. City, Town, or Location of Death Month Process (Section Name) 4. Courty of Death Month Process (Section Name) 4. Courty of Death Month Process (Section Name) 4. Courty of Death Name (Process Name) 4. C

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last)

	For State Registrar
Physician /Medical	1. Decedent's I
Examiner	4a. Facility Nar

Physician Medical									Month January	Day 29.	Year 2010	08:46 a M	
-	Exami		4a. Facility Name (If not institut		number)		4b. City, Town	, or Location of				inty of Death	
4	h*		Chester River	: HospitaJ	Center	c	Cheste	rtown			Ker	nt	
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 🖾 F	7. Age (In y	rs. last birthday)	If Under 1 Ye Months Da	ar If Under 2 ys Hours	4 Hrs. 8 Min.	B. Date of Birth (Month, Day,	Year)	9. Birthp Cour	place (State or Foreign
	Director		n/a	1 L M 2 L24 F	() Yrs.		1	46	1/29/20)10		MD
	pug *	1	Usual Residence of Decedent 10a, State 10b. Coun	tv	100	City, Town or Lo	cation					T ₁	0d. Inside City Limits
	sho	ō			100.								1 □Yes 2 X No
	the N	rect	DE Kent			Magnoli	a 10f. Zip Cod	e			Oa Citizen	of What Cour	ntrv?
	with	ä		aa Tana			1996			'	USA	or writer cour	M.y.
	eath	Funeral Director	141 Apple Cro		ecedent Ever in	U.S. 13.			in? (Speci	ifv Yes or No-		Race - Americ	can Indian.
10	fter d r Iten iner	F	1 X Never Married 2 ☐ Married	Armed arried 1 ☐ Ye	Forces? s 2 X No		Was Decedent of If Yes, specify C		Puerto Ri	can, etc.)		Black, White,	
036	urs a	þ	3 Widowed 4 Divorce	If Yes,	Give Dates:		1∐Yes 2 X ∏	No Specify:			Spe	ecify: Whi	te
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinate must be notified at	Completed by	15. Deced	ent's Education	dl		dent's Usual Oc kind of work do		of working		16b. Kind o	of Business/Inc	
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nd	be file d oth even	Be	17. Father's Name (First, Middl	e, Last)						First, Middle, N		name)	
yla	should be f and Mental I s marked ol umatic eve	၉	Chad E. Davis							n Wilds			
lar	2 short and less made managed		19a. Informant's Name/Relation				ng Address (Str				-		Code)
Baltimore, Maryland	permit, Pages 1 and 2 s Department of Health a Important: If item 27 Is any Injury or other trau once.		Kelly L. Wild	s/mother	Loo		Apple C		ne Ma			19962 on - City or To	Chata
0	Pages 1 nent of 1- int: If ite iry or ot		20a. Method of Disposition 1X□ Burial 2 □ Cremation	n 3 🗆 Removal fro	m State	p. Place of Dispo cemetery, crei	natory or other p	place)	Dat	ie .	20c. Locati	on - City or 10	own, State
Ë	permit, Page Department of Important: If any Injury of once.		4 Donation 5 ☐ Other		(Galena C			2/2/:			a, MD	
3a	permit Depar Impor any In		21. Signature of Funeral Service	e Licensee	1	l 2	Name and Adellows,	dress of Facility Helfer	bein	& Newn	am Fu	neral	Home
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			23a. Part 1. Enter the disease, shock, or heart failure. Li	or complications the st only one cause o	it caused the de n each line.	eath. Do not en	ter the mode of	dying, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. A)	ENCE	PHACY	/						
-	/Medical Examiner		resulting in death)	Due	to (or as a cons	equence of):							
	- Xaiiiiioi	<u>.</u>	Sequentially list conditions,	b									
	ted	ine	Sequentially list conditions, if any, leading to immediate	₹ Due	to (or as a cons	equence oi):							
	and and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	to (or as a cons	equence of):							
9	be e					. ,							
68760,	ficate phys s the	gi		d									
Box (death certificate be executed e attending physician and d for use as the burial-transit	sician/Medical	IF FEMALE: 23b. Was decedent pregnant		outcome of pre						23d.	. Date of delive	erv
ă	death atte	ciaı	in the past 12 months? 1 ☐ Yes 2 ☑ No		ve birth 2□F egnant at time o		☐ Ectopic pregn☐ Other (specify					Month	Day Year
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о. С.	The law requires that the ate has been signed by th bage 2 should be detache	y P	Part II. Other significant condi	tions contributing to	death but not i	esulting in the u	nderlying cause	given in Part I.		23e. Did tol	acco use	contribute to t	he cause of death?
rds	quires n sig uid be	q p								1 □ Y€	s 2 000	lo 3 ☐ Prot	oably 4 🗌 Unknown
00	w requires been signal	lete								24a. Was a	n 2	4b. Were auto	ppsy findings available
Re	he lav e has age 2 :	Completed by		-						autops perforr	ned?	prior to co death?	mpletion of cause of
of Vital Records,	ysician: The ils certificate h director, page		25. Was case referred to medic	cal				26 Place	of Dooth /	1 ☐ Yes : Check only on	2)KJ/No	1 ☐ Yes	2 LI No
<u>=</u>	Physician: r this certifica ral director, p	o Be	examiner? 1∐Yes 2∭No	Hoenital	Innatient 2	☐ ER/Outpatie	nt 3 🗆 DOA	Othor:		e 5 🗆 Reside		Other (Specia	fv)
ō	g Ph er thi	Ë	27. Manner of Death	28a. Da	te of Injury	28b. Time o		njury at Vork?		d. Describe ho			
Division	ath. T: Aft	ațio	Natural 5 Pend 2 Accident inves	ding (M stigation	onth, Day, Year) Injury		vork? I∐Yes 2∐N	10				
Vis	Atte	iţi	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	rmined 286. Pla	ce of Injury - A	t home, farm, str	eet, factory, offic	ce	28	f. Location (Si	reet and N	umber or Rura	al Route Number,
Ö	al or s afte	Certification: To	4 Homicide	bu	ilding, etc. (Spe	scriy)				City or Town	i, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (ying Physician: To al Examiner: On the									
	o the	Me	29b. Signature and title of certif		1		29c. Lic	ense number		2	9d. Date si	gned (Month,	Day, Year)
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人			30. Name and address of person			J		1000 45					-
			100 BROWN	St. CHE	TERTO	tem 23a) (Type,	10 716	20 %	RED	DY O.	ARA	010 1	10
	Sta Registi		31. Date filed (Month, Day, Yea	ur) 32 -4 2010	. Registrar's Sig		(marker			•			

10-01363 Keith Davis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 04916 Certificate of Death 1- For State Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 3. Time of Death 2. Date of Death Physician/ Month Day February 14, 2010 2141 hrs 'çal Examiner KEITH BRIAN DAVIS 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Talbot **Faston** Easton Memorial Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Months Days Hours Country MARYLAND Director APRIL 25, 1970 1 XM 2 F 39 217-90-2039 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 X No 28a-f show STEVENSVILLE MARYLAND | QUEEN ANNE'S marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once. death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 21666 ۃ 616 BUCKINGHAM DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 펻 12 Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? 1 Never Married 2 X Married 2 X No Yes Specify: WHITE 1 Yes 2 X No specify: be filed within 72 hours after 4 Divorced If Yes, Give Year 3 Widowed ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 COMMERCIAL ELECTRICIAN 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental H. Important: If item 27 is marked of injury or other traumatic event, the JACQUELINE MARGARET TARUN Be WILLIAM ALLEN DAVIS, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) STEVENSVILLE, MD 21666 616 BUCKINGHAM DRIVE, TINA DAVIS/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place.
CHESAPEAKE FEBRUARY 16 1 Burial 2 X Cremation 3 Removal from State STEVENSVILLE, MARYLAND CREMATION CENTER 2010 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he Physician failure. List only one cause on each line Death /Medical Myocardial fibrosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - tran Physician/Medical AMENDED 23a,27,permE, X UNPENDED g901 3/23/10 TT The law requires that the death certificate be 23d. Date of delivery P.O. Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year 3 Ectopic pregnancy Month Day 23b. Was decedent pregnant in the Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ò Completed 24b. Were autopsy findings available Division of Vital Records, 24a. Was an has been prior to completion of cause of autopsy death? performed? 1 🗸 Yes Yes 2 No certificate 26 Place of Death (Check only one) 25. Was case referred to medical Be Other₄ Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 Nursing Home 5 Residence 6 Other After this 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 5 1 X Natural 1 Yes 2 No Pending the Certificati Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e Place of Injury - At home, farm, street, factory, office building, etc. 3 📗

Hospital or Attending Physician: in by t within 24 hours after To the Funeral Dire

the

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cal

State Registrar

6 Could not be Suicide determined

Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 15, 2010

Donna M. Vincenti, MD 31. Date filed (Month, Day, Year)

Registrar's Signatur

DHMH 17 Rev 1/2001

ORIGINAL

10-01160 Terry S Douglas

Ferry S Douglas	1- For State Certificate of Death 2010 119									10 0491			
Physician.	1/	Registrar 1. Decedent's Name (First, Midd	fle, Last)					2. Date of Dear		3. Time of Death			
Medical Examine	ш.	TERRY S.	DOUGLAS					Month February 8		1038 hrs			
	×	4a. Facility Name (if not instituti Prince George's Hos		er)		4b. City, Town, or t Cheverly	ocation of Dear	th	4c. County of Prince Ge				
Funeral		5. Social Security Number		Age (In vrs.	last birthday)	If Under 1 Year	If Under 24H	rs 8 Date of Bir		Birthplace (State or			
Director		577-80-7730	1 M 2 X F		50 Yrs	Months Days	Hours Mi		1	Foreign Country) WASH., DC			
	ŀ	Usual Residence of Decedent	- W - ZA -		JU 113			103-14-	-1939	wASH.,DC			
any	Ī	10a. State 10b. County		10c, City	, Town or Locat	ion				10d. Inside City Limits			
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the Maryland a or 28a-f sh tiffed at one	20	10e. Street and Number				10f. Zip Code		11	0g. Citizen of What	t Country?			
ith the 23a o notifi	<u>-</u>	7721 GREENLEAF				20785			U.S.A.				
death with ritems 23.		11. Marital Status 1 X Never Married 2 N	12. Was Decede Armed Force	es?v		s Decedent of Hisp es, specify Cuban,			- 14. Race White,	American Indian, Black, etc.			
fler de	-1	3 Widowed 4 Di	1 Yes vorced If Yes, Give Year	2 No	1	Yes 2 X No	specify:		Specify:	BLACK			
ours aft atural' xamine		15. Decedent's Education (Spe	or Dates: ecify only highest grade c	completed)		t's Usual Occupation			16b. Kind of Busin	ness/Industry			
16 n 72 h san "n ical E		Elementary/Secondary (0-12)	College (1-4 c	or 5+)		ost of working life.	DO NOT use re	urea)					
-0036 within 72 hour giene. her than "natu LMddical Exau	Ē	12TH GRADE 17. Father's Name (First, Middle	Last)		U.	NKNOWN	9 Mothoda Nom	ne (First, Middle, N	UNKNOW	/N			
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MD and 2 sho alth and m 27 is aumati	L	IDA MAE DOUGLA	S-MOTHER						, MD 2078				
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Page ment or oth		4 Donation 5 Other S	pecify:					-17-2010	CLINTON	, MD			
Baltimore, permit. Pages I ar Department of Her Important: If ite	İ	21. Signature of Funeral Service	Signature of Funeral Service Licenses 22. Name and Address of Facility PINCKNEY—SPANGLER F. 524 — 8TH STREET, N. E. WASHINGTON, D.										
Physician	+	23a. Part I. Enter the disease, or	complications that cause	the death									
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and and	<u></u>	X UNPENDED	d										
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6876 errificate ding phy	<u> </u> 2	3b. Was decedent pregnant in to past 12 months?	he 1 Live birth		2 Fe	tal death 3	Ectopic pregn	ancy	Month	Day Year			
Box 6876/ e death certificate the attending phy ad for use as the the the standary and the standary and the standary and the standary and the standary and the standary and the standary and the standary and the standary and the standary and the standary and the standary and the standary and the standary and the standard and the		1 Yes 2 No 9 Un	known 9 Unknown	at time of de	eath 5 Oth	ner (Specify)							
D. BC tribe des by the a sched fo		Part II. Other significant condi		ath but not r	esulting in the u	nderlying cause giv	ven in Part I,	23e. Did to	bacco use contribu	ite to the cause of death?			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P.								1 Yes	2 No 3	Probably 4 🗸 Unknown			
ords, w requir is been s should	ומני							24a. Was a		ere autopsy findings available or to completion of cause of			
Records, The law requires ficate has been sig, page 2 should be Completed								perfor	med? dea	ath? Yes 2 No			
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n of ding Ph. h. After t funeral		27. Manner of Death 1 Natural 5 Pen	28a. Date of Ir (Month, Day	njury v.Year)	28b. Time of Ir		at Work?	28d. Describe h	ow injury occurred I was fou	subject used nd in a cold			
Sion Atten	<u> </u>	2 X Accident Inve	stigation Fd 2/8		Fd 8:53	t, factory, office but		environm	nent	or Rural Route Number, City			
Division ospital or Attending nours after death. neral Director: After filed in by the func Certification:			a not be		in porch		g, oto.	or Town, St Hyattsvi	tate) 7721 G	reenleaf Rd			
		20a Codifice	hysician: To the best of				e and place, and						
To the Howithin 24 To the From the From the From the From Political			miner:On the basis of ex and manner stated		nd/or investigati	ion, in my opinion, o	death occurred	at the time, date a	and place, and due	to the cause(s)			
E S		29b. Signature and title of certific	40/1/	1308	U .	29c. License				(Month, Day, Year)			
		(ulor late	er veel			O.C.M	.E.		February 9, 2	2010			
P	3	30. Name and address of person Victor Weedn MD JD	who completed cause of Assistant Medic	. '		enn Street, Ba	ltimore MD	21201					
State	e (r's Sign it		Jan Jacci, Da							
Registra		FEB 1 6 2010	Museum L	7. 494	FULL					j			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month F. Decedent's Name (First, Middle, Last) Richard Physician Allan Feb. 13, 2010 3:50P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Dennett RD. Nursing Home Oakland Garrett 7. Age (In yrs. last birthday 73 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/30/1936 Birthplace (State or Foreign Country)
 PA 5. Social Security Number **Funeral** Months Days Hours 1 X M 2 □ F 213-32-6107 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show s 23a or 28a-f sho ust be notified at Director 1 ☐ Yes 2 No WV Tucker Parsons 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5560 Limestone Mtn. Rd. 26287 USA Funeral filed within 72 hours after death items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after des Important: I death and Mental Hygene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, it. Wedien Eran in any injury or other traumatic event, it. Wedien Eran in any 14. Race - American Indian, Black, White, etc. 1 □XYes 2 □ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Electromotive Elementary/Secondary (0-12) College (1-4or 5+) Division Manager/General Motors 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Sara Jessie Elms 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bonnie J. Elms/Wife 5560 Limestone Mtn. Rd. Parsons, WV 26287 20b. Place of Disposition (Name of Sugares entering the Place of Disposition (Name of Sugares) (Name of Sugares) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☆ cremation 3 ☐ Removal from State Gardens Crematory 02/15/2010 Kingwood, WV 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hinkle Funeral Home, Inc. 21. Signature of Funeral Service Licensee POBox 186 Davis, WV 26260 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Physician Zyears disease or condition resulting in death) Static /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and -transit Division of Vital Records, P.O. Box 68760, 🧾 Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FFMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) detached ☐Yes 2 ☐No 9 Unknown 9 🗌 Unknown as been signed 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe page 2 □No 1 ☐ Yes 1 🗌 Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Unrsing Home 5 Residence 6 Other (Specify) 2 0 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 30. Name and address of person who

31. Date filed

(Month, Day, Year)

DHMH 17 Rev 1/2001

ghway oaklard, ud 21550

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Geoffrey Beirne Freeman, Jr. February 03 2010 9:22 Ам Medical a. Facility Name *(if not institution, give street and number)* 28541 Clubhouse Drive or Location of Death 4c. County of Death 4b City, Town, Easton **Examiner** Talbot If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 173–05–8004 8. Date of Birth 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 08^MTO /TY921 Delaware Director 88 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Easton Talbot 1 Yes 2 X No Maryland 10f, Zip Code 21601 10g. Citizen of What Country? United States 10e, Street and Number 28541 Clubhouse Drive by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates.1942-45 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cemeterv Owner/Consultant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Ethel L. Grey Geoffrey B. Freeman, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 28541 Clubhouse Drive, Easton, Maryland 21601 Susan Dawson Freeman/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 02/18/2010 Arlington, Virginia 22. Name and Address of Facility George F. Kalas Funeral Home 21. Signatur Service Licenses 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Opset and Death Immediate Cause (Final seind Physician/ disease or condition resulting in death) Medical Due to (or as a consequent Examiner on car Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed? Yes 2 A No for 1 🗌 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) Hospital 2 **X** No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 02/04/2010 H42587 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Russell Alan Schilling, 555 Cynwood Drive, Easton, Maryland 21601 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

Registrar
DHMH 17 Rev 7/2009

FEB 04

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death Physician/ Godfrey 2010 10:30A George Henry Sr. January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Queen Anne's 237 Coleman Rd Sudlersville If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Min. Days 1 XM 2 - F Months Hours 870971932 Director 146-26-4660 77 Usual Residence of Decedent and Mental Hygiene. In a marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other the Medical Examiner must be notified at 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Sudlersville MD Queen Anne's 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21668 237 Coleman Rd. 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, 1 Never Married 2 X Married ρ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White Specify Specify: 3 Widowed 4 Divorced Completed Year or Dates. n/a 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked or Department of Health and Ment.
Important: If item 27 is marked any injury or over ည Robert Edwin Godfrey Hazel Wells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Godfrey/wife 237 Coleman Rd. Sudlersville, MD 21668 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Luke's 2/1/2010 Church Hill, MD 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 370 W. Cypress St. Millington, MD 21651 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause up neach life. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ar 50 disease or condition 415 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or iinjury that initiated events southing in deeth). Let Examine Due to (or as a consequence of): and Due to (or as a consequence of): resulting in death) Last the attending physician the for use as the buna Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.
b Funeral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of De 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

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29b. Signatur

only one)

30 Name and addre Way 31. Date filed (Monti

and title of certifie

s of person who completed cause of

death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

signed (Month, Day, Year)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ JOLDMAN Month 2010 083UM ARNET 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mandrin Chesapeake Hospice House Anne Arundel Harwood 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 ☐ M 2 🗹 F West Wirginia 05/18/1921 236-38-8097 88 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Marvland Anne Arundel Edgewater 10e. Street and Number 10g, Citizen of What Country? 87 Stewart Drive, Apt. 332 21037 United States e filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify White Completed 3 Divorced 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) a d Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Grooming Hairstylist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Judson Hicks Willie Alice Harris Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 87 Stewart Drive, Apt. 332, Edgewater, MD 21037 Frank M. Goldman/Husband Health a 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) akemont Memorial Gardens 02/04/2010 Davidsonville, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home Signaty/e 2973 Solomons Island Road, Edgewater, MD 21037 rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trans Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Vear Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 TYes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? USPICE 2. No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of contifie 1010 no completed cause of death (Item 23a) (Type, Print Name and address of person EFE NSE HIGHWAM ANNAPOLYM D ZIYU m 445 31. Date filed (Month, Day, Year) FEB 03 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2 010 Physician/ Fleske 3:30 AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Anne Arundel Anne Arundel Center Annapolis der 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Funeral 1 🔀 M 2 🗆 F Months Davs Hours Country) Month Day, Yar) 30 Director 270-26-0388 Ohio Usual Residence of Decedent 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No Annapolis Maryland Anne Arundel 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 3425 Hidden River View Road 21403 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No 55-75

If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced ed other than "nature event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Corporate Executive Flight Safety Int 54 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be thrent of Health and Ments rtant: If item 27 is marked njury or other traumatic e Gottlieb Gleske Olga Neisch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Gleske - Son 180 Logger Dr., Gore, VA 22637 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Important: If any injury or 2/4/2010 Baltimore Crematory Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Mydin T. Veloba 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) NEUMONI Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' After this certificate Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 X No 1 Yes Certificate: To 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Matural 1 Tyes 2 🗌 No Accident Suicide Investigation 6 \square Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Signature and title of certifier 29d. Date signed (Month, Day, Year) 27388 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) NHANSMAN, 137 Mitchells ChANCETISO, EDGEWATER MD 21037

Registrar

32. Registrar's Signature

Registrar

State

32. Registrar's ignatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Menth William Hill Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Alleganv Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday, 8. Date of Birth Month, Day, Ye Dec 11 1 □_M 2 □ F Months Days Hours Min. Country) Director 215-34-4295 1937 MD Usual Residence of Deceden or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Allegany Cumberland 1 ☐¥es 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 21502 18 Mullen Street USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black. White, etc. P à 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 ☐ No Specify: "natural", Completed Specify: 3 XVidowed 4 Divorced After 55 white Year or Dates the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic auces. Elementary/Seconday (0-12) College (1-4 or 5+) <u>foreman</u> Cumb. Water Dept. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Guv Hill Edna (Miller) Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 18 Mullen Street MD 21502 Leon Hill Cumberland son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/19/201 MD Cumberland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a d be detached for Division of Vital Records, P.O. contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performe certificate 1 Yes 2 No Yes 2 N as case referred to medical examiner? funeral director, æ 26. Place of Death (Check only one) Other: 2 No မ 1 🗌 Yes 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) Natural 5 Pending injury death. 1 Yes 2 No hours after death Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar only one)

30. Name and address of ber

31. Date filed (Month, Day, Year,

FEB 22 2010

on who completed cause of death (Item 23a) (Type, Print)

32. Registrar

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

- AVENUE SLUTE 105

29d. Date signed (Month, Day, Year)

CUMPERLAND MD ZISOZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ Year Marian Η. Heher 9:23 A 01 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicom a the 7. Age (In yrs. last birthday) If Under 24 Hrs. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min 096-09-2044 **Director** 14 | 1908 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21804 1003 Bayshore Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates white Specify. Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 executive secretary banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ellen F. McGuier Harry E. Herting 19a. Informant's Name/Relationship (Type, Print) Joseph Heher son 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 904 Colony Dr., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 2 2 10 4 ☐ Donation 5 ☐ Other (Specify) St. Charles Cemetery Farmingdale, NY 21. Signature of Funeral Ser 22 Holloway Funeral Home, Horioway Funeral Home, Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ CARDIOMYOPATH disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown 5 Other (specify) Month Dav Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 □ Probably 4 □ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes Z ☐ No Hospital: Other: မှ 4 Nursing Home 5 Residence Pother (Specify) HOSP (42 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide determined Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar only one

Hustin

31. Date filed (Month, Day, Year)

FEB 02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signa

WAR

00058410

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2010 HOWISON MARGA RET VIRGINA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NANTI COKE Inder 1 Year | If Under 24 Hrs. 0465 NANTICOKE Wicomico 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace Country) (State or Foreign **Funeral** Min. Days 1 □ M 2 DK Months Hours 69 FLCRIDA Director Usual Residence of Decedent 10d. Inside City Limits show 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No MD NANTICOKE WICOMICO 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ 72 hours after death with NANTICOKE DR. 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 Tolo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify WHITE 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced than "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, II* II* Elementary/Secondary (0-12) LuCollege (1-4or 5+) OCCUPATIONAL THEMAPIST MEDICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RALPH F. HOWISON SANE MCKENZIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Date 20c. Location - City or Town, State KEVIN MCKENZIE 27835 Cousin ISLAND DR Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 2-10-10 4 ☐ Donation 5 ☐ Other (Specify) TURNECS CEMETERY 2

22. Name and Address & Facility HANTICO KE IMD 21. Signature of Funeral Service Licensee 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MESSICK FUNCIAL HOME TO BOXEL BIVALVE MD 21814 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RESTRICTIVE LUNG DISEASE VEAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical as attending | IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) □Yes 2□No signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown ASTHMA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perfor certificate 2 No 1 ☐ Yes Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) NO 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After the Hospital or Attending Natural 2 ☐ Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 No within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 14/2010 D36576

State

31. Date filed (Mont)

Registrar
DHMH 17 Rev 1/2001

560 RIVERSIDE DR

SALISBURY MD 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TRAUSTEMD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Physician/ Month 2010^a Michael Charles Howard 2:00 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c, County of Death 233 Baxter RD Sudlersville Queen Anne's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**₹** M 2 □ F Months Days Hours Min. 1271371945 Mary Land 216-48-7498 64 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🎘 No MD Queen Anne's Sudlersville 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 233 Baxter Rd 21668 IISA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ģ Yes Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waterman Seafood Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Benjamin F. Howard Florence Wolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Howard Baxter Rd Sudlersville, spouse MD21668 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Carcemation 3 Removal from State Chesapeake Cremation CTR 2/9/10 Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Filiows, Helfenbein & Newnam FH 370 Cypress St Millington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Prysician ardiac disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to lo bunial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician The law requires that the death certificate be Physician/Medical Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy jo in the past 12 months? 5 Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown the signed by t Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☑ No 2 NO or Attending Physician: æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ☐ Natural ☐ Accident 5 Pending 1 Tyes 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

the Hospital Tm

> State Registrar

Medical

29a. Certifie

only one

Nasir

29b. Signature and

title of certifier

Ramin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

119c North main

32. Registrar's Signature

1 Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0069453

Galena MD

29d. Date signed (Month, Day, Year)

8 10

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Henrietta aragiret Januar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** hester River Hosp. tal Center hester If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 🛛 F Director 220-28-2177 76 6/8/1933 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Evanciant must be notified at 10c. City, Town or Location 10b. County Director Queen Anne's Chestertown 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 107 Hynson Rd. 21620 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Production Worker Campbell 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Orvelle Brown ဥ 19a. Informant's Name/Relationship (Type. Print) Otha N. Hynson/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Pleasant Cemetery 1/30/10 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or o implications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LIVER FAILURE **Physician** /Medical Due to (or as a consequence of) Examiner METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit physician and the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 HYPERWAGULABLE STATE Completed 24a. Was an

28a. Date of Injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Mary Belle Wilkerson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Hynson Rd. Chestertown, MD 21620 20c. Location - City or Town, State Pondtown, MD 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home
370 W. Cypress St. Millington, MD 21651 Approximate Interval Between Onset and Death days PANCREATIC CANCER 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑No was an autopsy performed? 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 500 41587 29d. Date signed (Month, Day, Year) 1-25-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 122 SPEER RD, CHESTERTOWN, MD 32. Registrar's Signature **ORIGINAL**

1532

Birthplace (State or Foreign Country)

DE

1 ☐ Yes 2 X No

10d. Inside City Limits

23

4c. County of Death

IISA

14. Race · American Indian,

Black, White, etc.

Specify: Black

6

State Registrar

Be

Certification: To

Medical

25. Was case referred to medical examiner?

5 Pending

PRIEN A. NOBLE, MD

investigation 6 ☐ Could not be

determined

1 Yes 2 No

27. Manner of Death

1 Natural
2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

10-00390

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene Gilbert Hynson, Jr. Certificate of Death Reg. No. Registrar 2. Date of Death 1 Decedent's Name (First Middle Last) Physician/ Month Day January 13, 2010 GILBERT CLIFTON HYNSON, JR 1710 hrs Medical Examiner 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death 26783 Dutchtown Road Still Pond Kent 5. Social Security Number 7. Age (In yrs. last birthday If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or If Under 1 Year **Funeral** Months Days Hours Min 213-74-8276 Director 53 12/15/1956 1X M 2 F Country) Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location STILLPOND 1 Yes 2 X No KENT MD or items 23a or 28a-f shov must be notified at once, imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Montal Hygiene.
Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21667 21683 DUTCHTOWN RD Funera 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 Yes BLACK 3 X Widowed f Yes, Give Year 1 Yes 2 X No specify: 4 Divorced Specify ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) KENT CO STATE DEPT 12 CONSTRUCTION 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) AGNES LUCILLE TILLER GILBERT C. HYNSON SR Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 150 FLATLAND RD APT 40 CHESTERTOWN, MD 21620 GILBERT C. HYNSON, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) partment o DIRECT DOVER, DE CREMATORYLL Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 19904 BENNIE SMITH FH 717 W DIVISION ST DOVER, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. Medical Death Subarachnoid hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Ruptured berry aneurysm Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and - transit law requires that the death certificate be executed Physician/Medical X UNPENDED physician the burial -AMENDED PI line a-b, 27, per EM g900 2/23/10 TT Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Month Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknowr signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, peen 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate I page 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) director, of Vital Be examiner? Hospital: 1 Inpatient 2 Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 🗸 Yes ပ 2 No 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification 1 X Natural 1 Yes 2 No Pending the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certifi OCME January 14, 2010

DE

State Registrar

DHMH 17 Rev 1/2001

OCME 2006

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32. Regir (rar's Signature

111 Penn Street, Baltimore, MD 21201

		1	For State Registrar	State of Ma	•	partment of Health e <i>rtificate of Death</i>		ygiene Reg. No.2001	01030
			Decedent's Name (First, Middle	, Last)	-	· · · · · · · · · · · · · · · · · · ·	2. Date of D	eath 2011	3: Time of Death
	Physicia Medic		Kenneth D	ale Hodanics	Sr.		Febru	ary 7 201	0 18:32 PM
	Examin	_	4a. Facility Name (if not institution,	give street and number)		4b. City, Town, or Location	n of Death	4c. County of Dea	ath
- 18			Union Hospital			Elkton	04 Hrs. To B () 6 B	Cecil	: 11 - 10 - 10 - 10 - 10 - 10 - 10 - 10
	Funeral Director		5. Social Security Number 212–50–3206	1 X XM 2 □ F	In yrs. last birthday Yrs.	/) If Under 1 Year If Under 1 Months Days Hours	er 24 Hrs. 8. Date of B Min. (Month, L Aug.	1,1952 Mar	irthplace (State or Foreign country)E1kton y1and
	and show d at	ē	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location			10d. Inside City Limits
	Mary 28a-f otifie	Funeral Director	Marvland Ceci	1	No	orth East			1 ☐ Yes 2 ☐ No
	h the	<u>=</u>	10e. Street and Number			10f. Zip Code		10g. Citizen of What C	-
	th wit ms 23 must	ie l	8 Puschell Lan		3-110	21901 3. Was Decedent of Hispanic C	Vising (Specify Vos or Ne	United Sta	
920	should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "hatural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 ☐ Never Married 2 ★Marr 3 ☐ Widowed 4 ☐ Divorced	If Voc Civo		Was Decedent of Hispanic C If Yes, specify Cuban, Mexic □ Yes 2 No Specing	an, Puerto Rican, etc.)	Black, Wh	
21215-0036	72 hou n "natu ledical	nplet	(Specify only highe	nt's Education est grade completed)	(Gi	cedent's Usual Occupation ve kind of work done during mo DO NOT use retired)	ost of working	16b. Kind of Busines	s Industry
712	vithin iene.	Co	Elementary/Seconday (0-12)	College (1-4 or 5+) [ter Automotive	Technician	Automotiv	·e
b	iled w Il Hyg I othe vent,	Be	17. Father's Name (First, Middle, L	ast)			ther's Name (First, Middl		
Maryland	d be dents Ments arked	입	John Hodanics,	Sr.			ora Harvey		
lan.	1 and 2 should be if Health and Men item 27 is marke other traumatic	Ш	19a. Informant's Name/Relations			ailing Address (Street and Num			
2	and 2		Sharon P. Hodan	nics / Spouse		Puschell Lane,		20c, Location - City	21901
more	Page 1 and nent of Heal nt: If item :		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (\$	3 ☐ Removal from State	cemetery, c	sposition (Name of crematory or other place) Le Crematory	February 12, 2010	Newark, De	
Baltimore,	permit. Page 1 s Department of I Important: If ite any injury or ot		21. Signal Fune a Service 1			22. Name and Address of Fac 127 South Main	Crouch Fu		Jarvland21901
			23a. Part 1. Enter the disease, or	r complications that caused t					Approximate
	nysician/		Immediate Cause (Final	only one cause on each line.	A.# (D) (A) 1	INFARCTION	1 =		Interval Between Onset and Death
	Medical		disease or condition resulting in death)		consequence of):	474471101101			
	Examiner	_	Sequentially list conditions,	b. Coro		AKTELY DIS	EASE		YEARS
	d it	nine	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):				
	ecute and I-trans	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	C. Due to (or as a	consequence of):				
0	cate be executed physician and the burial-transit	edical	,	L _d					
3760	ficate g phy as the	Med	IE EENAME:					1	
Box 687	ath cert	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at	Fetal death	3		23d. Date of o	delivery Day Year
Ä.	he deg	hysid	1 🔲 Yes 2 🗌 No 9 🔲 Unknown	g 🗌 Unknown	anio oi doda				
, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditi		t not resulting in th	ne underlying cause given in Pa		d tobacco use contribute	to the cause of death?
rg	requir been s	ete					24a, Wi	as an 24b. Were	autopsy findings available
Records,	he law te has age 2 s	Completed					pe	rformed? death	to completion of cause of ? Yes 2 No
al F	ian; T rtifica stor, p	Be C	25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)		
of Vital	hysic his ce I direc	은	1 Yes 2 No		nt 2 ER/Outpa			esidence 6 Other (Sp	ecify)
o	ing Pl	ate:	27. Manner of Death 1 Natural 5 Pendi	28a. Date of injury ing (Month, Day,	/ 28b. Tim- Year) injui	y work?	l	e how injury occurred	
sior	ttend death stor: A	Certificate:	3 Suicide 6 Could		v - At home, farm.	M 1 ☐ Yes 2		n (Street and Number or I	Rural Route Number
Division	al or A	Cer	4 L Homicide determ	building, etc.	(Specify)	etroot, factory, emee		Town, State)	
	Hospi 24 hour Funera eted fille	Medical	(Check 2 Medical	Examiner: On the basis of ex	amination and/or in	ath occured at the time, date an evestigation, in my opinion, death ge, death occurred at the time, c	n occurred at the time, dat	te and place, and due to th	ne cause(s) and manner stated.
	To the within To the complex	Σ	only one) 3 L. Certifying 29b. Signature and title of certified		COL OF THE KITOWIEU	29c. License numbe		29d. Date signed (Mo	
	0	l l	1 6 h	40		D0047	111	FEBRUA	ex 8.3010
)								127 1700
·)		30. Name and address of person			pe, Print)	3 ELLITON	U MARKLA	

			For	State of Marylan				d Mental Hygi	ene 0 1 0	04931
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	rtificate o	Deam	2. Date of Deat	og. No.	3. Time of Death
	Physici	an		11-05				Month 3	Day Year	0835 AM
7	/Medic		4a. Facility Name (If not institution, give s	HOGINS	<u>-</u>	4b. City. Town	, or Location of D		4c. County of Death	V 3 2 3
	Examin	er	527 Alamban	砂田	26	2	alisbu		Wico	mico
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Yea Months Day		Min. (Month, Day,	Year) 9. Birth	place (State or Foreign intry)
	Director		212-40-1007	M 2 🗆 F	ole Yrs.			8-21-	.1943	VA
	land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	Mary	ţ	MD Wicom	uco C	salis	bury				1 Pes 2 No
	or 28g	irec	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What Cou	intry?
	ath wi	Funeral Director	527 Alamba				1801		(4,5	H
	er der Itame	une	11. Walkar Olaros	12. Was Decedent Ever in U Armed Forces?	S. 13.	Was Decedent o If Yes, specify Ci	f Hispanic Origin uban, Mexican, P	? (Specify Yes or No- ruerto Rican, etc.)	14. Race - Amer Black, White	
36	d within 72 hours after death with the Maryland Jiene. r than "natural", or Itams 23a or 28a-f ahow the Medical Examiner must be natilled at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates:		1□Yes 2⊅N	lo Specify:		Specify: B	lack
21215-0036	72 hou	ted	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occ	cupation ne during most of		16b. Kind of Business/I	ndustry
21	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	DO NOT use reti	ired)	3	Perdu	.0 _
	filed w Hygier ther ti		17. Father's Name (First, Middle, Last)			Clean	18 Mother's	Name (First, Middle, M		
Maryland	a a b	9 Be	TALLET S INALITE (F 1151, INTIGUIE, EASI)	Bailey			00	ary Ho	Dains	
Z	and Men le marke sumatic	2	19a. Informant's Name/Relationship (Ty		19b. Mailin	ng Address (Stre			City or Town, State, Z	ip Code)
	1 and 2 Heelth a am 27 le		Lavoris Teag	te Friend	102	Toold	CT	YORKtow	n VA 2	3692
Baltimore,	t to		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	20b. F	lace of Dispo emetery, crea	sition (Name of matory or other p	olace)	Date	20c. Location - City or 1	Town, State
Ě	Pag ant:		4 □ Bonation 5 □ Other (Specify)		oringhi	ill Hen		18/2010	Hebron	MO
Bai	Department Page Important: Page Important: any injury once.		21. Signature of Funeral Service License	Lul_	-	2. Name and Add	dress of Facility	14.		· Isabellast
			23a. Part1. Enter the disease, or compli	cations that caused the deat		ennie S	tying, such as car	ineral 130h		Approximate
	Dhusisian		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	0/	h	4			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	uence d):	NAS B				18 WW
и	Examiner		Sequentially list conditions	D						
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	usrice of):	. .				
	end end I-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	rate be executed thysicien end the burial-transit	cal E			201.00 0.7.					
687	ficate p phys is the			D	<u> </u>					
Вох	eath certific ettending p for use as 1	M/W	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		⊒Ectopic pregna	ncv		23d. Date of deli	- /
	the etter	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of o		Other (specify)			Month	Day Year
P.0	thet the de ed by the detached	Phy	9 Unknown				ausa ia Daet I	23a Did tol	pacco use contribute to	the cause of death?
	The law requires that the death certificate be executed the las been signed by the ettending physicien end age 2 should be detached for use as the burial-transit	Ď	Part II. Other significant conditions con	nthouting to death out not res	ulting in the t	inderlying cause	given in Part I.	236. Did tol		. 1
Ö	w requ been shculo	etec						24a. Was a		topsy findings available
Vital Records,	The lay	Completed					<u> </u>	autops perform	ned? prior to death?	completion of cause of
ta		0	25. Was case referred to medical				26. Place of	1 ☐ Yes : Death (Check only on	No 1 Yes	2 No
Ξ	Ø 12. Z	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA	Other: 4 🗆 Nursi	-/	ence 6 Other (Spec	cify)
n of	ding Ph h. After th funeral		27. Manner of Death ↑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	28c. Ir	njury at Vork?	28d. Describe ho	ow injury occurred	
sio	Attending in death. actor: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be	<u> </u>			☐Yes 2☐No			-10
Division	l or At efter d Diracl	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special		reet, factory, offi	ce	City or Town	treet and Number or Ru n, State)	irai Houle Number,
_	spital nours neral filled			sician: To the best of my kno	owledge, deal	th occurred at the	e time, date and	place, and due to the c	ause(s) and manner as	stated.
	To the Hospital or Attent within 24 hours efter deat! To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	ition and/or ir	nvestigation, in m	ny opinion, death	occurred at the time, d	ate and place, and due	to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier			29c. Lic	ense number	1	9d. Date signed (Monta	h, Day, Year)
•	The same		1 / WON	no			105	0 /	2/3/10	/
2	Mar		30. Name and address of person who co	ompleted cause of death (Iter	n 23a) (Type 1 1/	Print)	(ppp	ou St	(nuco.	ma)
18	St	ate	31. Date filed (Month, Day, Year)	32. Aegistrar's Sign	aturge /	0 1	MAKE	00031	-17 VA 13 V	10-47
2-	Regist		FFR 0.5 20	10	B. 14	arke				/

			1 - State of State of Registrar	,	Department of He Certificate of De	aith and Mental H <i>eath</i>	lygiene Reg. No. ?	01.032
			1. Decedent's Name (First, Middle, Last)			2. Date of Month		3. Time of Death
	Physi- /Med		Mary Elestine	Harrison			- 09-301	0 1:50 AM
	Exam		4a. Facility Name (If not institution, give street and number of the st		4b. City, Town, or Lo		4c. County of De	eath omico
	Filmon			Age (In yrs. last birt	thday) If Under 1 Year	f Under 24 Hrs. 8 Date of I		Birthplace (State or Foreign Country)
	Funera Directo	_	219-26-9550 1 M 2 M F		Yrs. Months Days	Hours Min. (Month, 09 20	Day, Year) 1937	Maryland
	pur		Usual Residence of Decedent 10a. State 10b. County	10c. City, Towr	n or Location			10d. Inside City Limits
	Maryle f shor	ō	Maryland Wicomico		isbury			1 ∐Yes 2 ∏ No
	h the r 28a	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What	Country?
	th with 23a o ust be		7426 Austad Lane		21801		USA	
	be filed within 72 hours after death with the Maryland hall Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Me-keal Examiner must be notified at	Funeral	Armed Ford		13. Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Specify Yes or Mexican, Puerto Rican, etc.)	No- 14. Race - Ar Black, W	nerican Indian, hite, etc.
2 5	urs aft sal", or	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give 3 🗷 Widowed 4 ☐ Divorced Year or Dat		1 ☐ Yes 2 🔀 No	Specify:	Specify:	white
7 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	72 hor	Completed	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occupati (Give kind of work done dur life. DO NOT use retired)	on ring most of working	16b. Kind of Busines	ss/Industry
- 7 5	filed within Hygiene. ther than "	mple	Elementary/Secondary (0-12) College (1-4	for 5+)	bookkeeper		Maryland N	Material Ctr.
	filed v Hygie	Be Co	17. Father's Name (First, Middle, Last)			8. Mother's Name (First, Midd	-	Acceptate out
7 200	should be nd Mental marked o	To B	John L. Hudson			Mollie E. Guy	7	
ນ	S S S S		19a. Informant's Name/Relationship (Type. Print) Danny Harrison son	19b		d Number or Rural Route Nui Road, Salisbur		
	1 and 2 Health tem 27 i		20a. Method of Disposition	20b. Place of	f Disposition (Name of ry, crematory or other place)		20c. Location - City	
カ さ	Pages nent of lint: If Ite		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)		ry, crematory or other place) oury Cremator		Salisbury	, MD
Mary	permit. Pag Department Important: I any injury o	š	21. Signature of Funeral Service Licensee		22 Name and Address HOLLOWAY F	of Facility uneral Home Pr ill Rd., Salis	cofessional	Association
	1 88 E 6 8		W K balling f	CFSP	501 Snow H	ill Rd., Salis	sbury, MD 2	
			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea		not enter the mode of dying,	such as cardiac or respirator	y arrest,	Approximate Interval Between Onset and Death
	⊸ Physiciaı ✓ /Medica	_		r as a consequence		W CARC	inount	
	Examine			r as a consequence	01).			
	· ·	iner	Sequentially list conditions, if any, leading to firm clast cause. Enter Underlying Cause (Disease or injury	гая в ситянически	of)r			
	recute and I-trans	Examiner	that initiated events	r as a consequence	of):			
03200	ificate be executed physician and ts the burial-transit	Sal E	d					
	rtificating phy as the	Aedical	Tre services	-				
200	leath certif attending I for use as	ian/N	23b. was decedent pregnant	ome pf pregnancy th 2 Fetal death			23d. Date of Month	delivery Day Year
	The law requires that the death cert ate has been signed by the attending age 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Live oil 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nt at time of death vn	5 ☐ Other (specify)		_	ŕ
	ires that the de signed by the		Part II. Other significant conditions contributing to dea	ath but not resulting in	n the underlying cause given	in Part I. 23e. D	id tobacco use contribute	e to the cause of death?
7	w requires been sign should be	ed by				1	☐Yes 2☐No 3☐	Probably 4 Unknown
	law re	Completed				24a. W	/as an 24b. Were utopsy prior	e autopsy findings available to completion of cause of
-	sician: The law sertificate has the lage 2 sertificate has the lage 2 sertificate has the lage 2 sertificate has the lage 2 sertificate has the lage 2 sertificate has the lage 2 sertificate has the lage 2 sertificate has the lage 2 sertificate has the lage 2 sertificate has the lage 2 sertificate has the lage 2 sertificate has the lage 2 sertificate has the lage 2 sertificate has the lage 3 serti	Con				1		
**	siclar sertif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ In	patient 2 ER/Ou	Othor	26. Place of Death (Check on 4 □ Nursing Home 5 □ R		Consideration of the Court of t
3	or Attending Physician: ifter death. Director: After this certifici	⊢	27. Manner of Death 28a. Date o	Injury 28b.	Time of lnjury Work?		be how injury occurred	specify) TUSFICIC
	Attendin death. sctor: Af	atio	2 Accident investigation		M 1 □ Y	es 2□No		
	or Att	Certification:	determined 200. Flace	of injury - At home, fa g, etc. <i>(Sp</i> ec <i>ify)</i>	arm, street, factory, office	28f. Locatio City or	n (Street and Number of Town, State)	r Rural Route Number,
	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the					
	the Ho in 24 h the Fu	Medical	(Check only 2 Medical Examiner: On the ba					
	Vith To 1	Σ	29b. Signature and title of certifier		29c. License	number	29d. Date signed (M	onth, Day, Year)
	100		30. Name and address of person who completed cause	of death (Item 22a)	(Type Print)	0170 200	11011	
	10 mp		30. Name and address of person who completed cause	No Box	1737 57	tassury	us 21.	202
		tate	31. Date filed (Month: Day, Year) 32. Re	gistrar's Signature	barre	/		
	Regi	strar	2010 2010	p.	19			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of M	laryland					and M	lental H	ygiene	9	^	01000
			State Registrar			Ce	rtificate	of D	eath			Reg. No	201	U	14933
r	Physici	ian	Decedent's Name (First, Middle,								Date of D Month	eath Da	y	ear	3. Time of Death
1	/Medi	cal	Dortha Tull He 4a. Facility Name (If not institution,		1		4b. City, To	wo or l	ocation o	f Doath	Februa		3 20 County of		1:30 AM ™
1	Examir	ner			,		i			Deam		1	Wicon		
- 20	Funeral		Wicomico Nursin 5. Social Security Number 6	i. Sex 7. A	ge (In yrs. I	ast birthday)	If Under 1	Year			8. Date of B	irth		9. Birth	place (State or Foreign
ю	Director		222-07-1121	1□M 2፟፟፟፟X F		88 Yrs.	Months [Days	Hours	Min.	Jan. 18	B, 19		Cou Mar	yland
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or L	ncation								10d. Inside City Limits
	Maryle f sho ed at	ō		agtar		_									1 (∑Yes 2 No
	28a-	Director	10e. Street and Number	ester		Newark	10f. Zip C	ode				10g. Ci	tizen of Wh	at Cou	ntry?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.		7109 Daf	fodil Lane			218	41				U.S	.A.		
	ems ?	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S	S. 13.	Was Deceder If Yes, specify	nt of His	panic Orig	gin? (Spe	ecify Yes or N	10-		Ameni White,	can Indian,
36	s after	by Fu	1 Never Married 2 Married	d 1 ☐ Yes 2 ☐ If Yes, Give	No		1 ☐ Yes 25		Specify:	,	,		Specify:		white
Ö	hours tural" al Exa	q pe	3 🕱 Widowed 4 □ Divorced 15. Decedent's	Year or Dates		16a Dece	dent's Usual (Occupat	tion			16h k	(ind of Bus		
5	in 72 n "na fledic	plet	(Specify only highest	grade completed)		(Give	kind of work DO NOT use	done du	ırina most	of work	ing	100.7	and or Das	11033/11	dustry
212	d with giene. rr than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		Secret	ary				Ca	nning	Co	mpany
pu	al Hyg	Be	17. Father's Name (First, Middle, La	ast)				1	18. Mothe	r's Name	(First, Middl	le, Maidei	Surname,)	
ylai	ould b Ment arked aric e	은	Elwood Tull						Katl	heri	ne Bou	nds			
Jar	2 sho		19a. Informant's Name/Relationship	(Type. Print)		19b. Maili	ng Address (S	Street ar	nd Numbe	er or Run	al Route Num	ber, City	or Town, S	tate, Zij	Code)
(e)	1 and Health		Leigh Collings 20a. Method of Disposition	s (Great Ni			7 Fire		er Ro		Hebro Date		D 21 ocation - C	830	ourn State
Baltimóre, Maryland 21215-0036	ages nt of h		1 ☐ Burial 2 ☐ Cremation 3	B □Removal from State	e Ce	emetery, cre	matory or other	er place	i					-	
	artme artme ortani Injury		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lie	**	Gre		y of D				15-2010	De	ımar,	рe	laware
Ba	permi Depa Impo any Ir	Į.,) del	00			2. Name and hort F 3 East				t De	elmar	. DE	19	940
В			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that cause	ed the death					_			,	Ť	Approximate Interval Between
29	Physician		Immediate Cause (Final disease or condition		no scl	EPA	TIC C	AIL	DIA	ACC	ALL AR	0	ICTA	CZ	Onset and Death
\$	/Medical		resulting in death)	Due to (or a		uence of):	115	TE	DIOV		OLITE	- D	Str.	75	
п	Examiner	L	Sequentially list conditions.	b											
	sit sed	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a sonsaqu	ienee of):								-1	
	xecut and al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consequ	uence of):									
8760,	icate be executed physician and the burial-transit	dical E													
68	ifficate g phy as the	edic		u											
Вох	The law requires that the death certific are has been signed by the attending p page 2 should be detached for use as is	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth			⊒Ectopic preg	inancy					23d. Date	of deliv	ery
<u>.</u>	e deal	Sicis	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant 9□Unknown			Other (spec						Mont	h	Day Year
P. O.	nat the d by t etach	Phy	9 ☐ Unknown Part II. Other significant condition		hut not recu	ultine in the c	anderlyine equ		s in Dod I		1 ago Dio	l tabassa	una cantrib	uto to t	he cause of death?
ds,	ires tl signe I be d	þ	Fait II. Other significant condition	s contributing to death	Dut not resu	alang in the c	indenying cad	se giver	TITI Fatt I,			_			bably 4 Donknown
Ö	v requ	Completed											1		
Bec	has ge 2 a	Idm				·						ıs an :opsy rformed?∕	pr	ere aut or to co ath?	opsy findings available ompletion of cause of
	in: Th		25. Was case referred to medical	1					06 DI	-4 D4	1□ Yes	2 D Ki		Yes	2□No
>	ysicla s cert direct	To Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpat	tient 2 🗆 I	ER/Outpatie	nt 3□ DOA	Other	. /		n <i>(Check only</i> me 5□ Re		6 DOther	(Snec	f _t ()
0	Attending Physiclan: r death. ector: After this certific: by the funeral director, I		27. Mann of Death	28a. Date of In (Month, D	iurv	28b. Time o		: Injury Work?			28d. Describe				197
io	endin ath. or: Af he fur	atio	1 V atural 5 Pending 2 Accident investigat	tion	ay roar	ii ijai y	М		es 2 🗆 l	No					
<u>≅</u>	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Hornicide determina	ad Zoe. Flace of I	njury - At ho etc. <i>(Specif</i>)		reet, factory, o	office			28f. Location City or T	(Street a	nd Number e)	or Rur	al Route Number,
Ω	ospital o hours af uneral D ly filled ii		200 0 4 TV 2 4 TV 2	Dhadalan Talkaha		Teder des		Ale e Ale		1			-		
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	Vithin Vithin To the Comple	Ě	29b. Signature and title of certifier				_		number			29d. Da	ate signed	(Month	Day, Year)
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	an.		30. Name and address of person will Mahesha Thimmar			, , , , ,		ro T	on c	014	hum	an or	804	45	
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Registrar DHMH 17 Rev 1/2001 FEB 0 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 6°, 201°0° Ann Marie Keeny 4:10 PMM Medical 4b. City, Town, or Location of Death Frederick 4a. Facility Name (if not institution, give street and number) **Examiner** frederick Citizens Care & Rehabilitation Center 5. Social Security Numbe If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔯 F Months Davs Hours Min. 371-26-3734 81 **Director** 1928 Dec Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1X Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21702 U.S.A. 1900 Rosemont Ave. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married Yes 2XXNo Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates 3 XXWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Clerk/Medical Records 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marie Wischow Harold Hammond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20207 Robinwood Court, # 103, Hagerstown, MD 21742 David J. Keeny, son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory Feb. 9, 2010 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Smithsburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Keeney and Basford PA Funeral Home M00255 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause - n each line. lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Carelio Vas cules Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Die o (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that in the cause (Disease or iinjury) Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Day Pregnant at time of death 1 Yes 2 4 9 Unknown Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital 은 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of I 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? injury Natural 5 Pending 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director: completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 29d. Date signed (Month, Day, Year) 8 39 an 0 completed cause of death (Item 23a) (Type, Print)

State Registrar 30. Name and address of person who

Robert L. 31. Date filed (Month, Day, Year)

Kaufmann, M.D.,

32. Registrar's Signature

DHMH 17 Rev 7/2009

300 West Ninth Street, Frederick, MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dav Year Month Charles Donald Koester Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death SAUSBUR 4c. County of Death HOSPICE ATTELAKE LOASTAL WICOM 5. Social Security Numbe 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213-38-7002 Days Hours Min Director 69 Maryland Usual Residence of Decedent shov 10a. State 10b County 10c. City Town or Location the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 X Yes 2 No Wicomico Maryland Bivalve ь 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 1 items 23a 3998 Texas Road 21814 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. ð 1 Never Married 2 X Married Yes 2 X No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: white Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) 12 woodworker cabinetrv Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emma Sauer George Koester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3998 Texas Rd., Bivalve, MD 21814 Brenda Koester spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 2 1 10 Hanover, MD 4 ☑ Donation 5 ☐ Other (Specify) Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ alon disease or condition arein Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year vate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [호 Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed death? certificate 2 🗷 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 No Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) HOS Public ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after dearn.

To the Funeral Director: After this or the funeral director and the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 🗌 Yes 2 No ☐ Accident Investigation ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

29b. Signature and title of certifier

GREGORIO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. BELLOSO

oeste

DHMH 17 Rev 7/2009

Registrar

M.D.

Registrar's Signa

D 29505

5302 CHINABERRY DR. SALISBURY, MD 21801

01-31-10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 9900 2-22-10 yt State of Maryland Department of Health and Mental Hygiene 04936 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2303р м Gladys M. Lewis 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Regional 6. Sex COMIC 0 8. Datelof Birth 6 (Month, Day, Year) 7 - 7 - 1918 If Under 1 If Under 2 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Year Funeral 1 M 2 KF Days Months 214-28-3691 91 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State Director 1 Yes 2 XNo Hebron MD Wicomico 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8471 Memory Garden Lane U.S.A. 21830 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. Specify Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry n 27 is marked other than "n r traumatic event *** (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Farming Laborer 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 . Page 1 and 2 should be f ment of Health and Menta Florence Spence Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Janice Sylvestre/Daughter 9804 Seagull Ct, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Gard 2-5-2010 Hill Spring Hebron, MD Signature of Functal Service Licensee 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Salisbury, Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ ORONARY ARTERY Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last as the burial-transit and Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 0 in the past 12 months?

1 Yes 2 No Year Month Day signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 🔼 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2 020912 Name and address of person who completed cause of death (Item 23a) (Type, Print) CARROLL ST. SALISBURY Md mi Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 25 State of Manyland / Department of Health and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year 2010 Sayuki Lowe Tini Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner If Under 24 Hrs 8. Date of Birth If Unde 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F (Month, Day, Year) -13-1955 Davs Min. Months Hours Japan 620-56-9843 Director 54 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director 1 XYes 2 No Somerset Princess Anne MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral items 23a U.S.A. 21853 30494 Valentine Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò 1 Never Married 2 Married ģ Saltimore, Maryland 21215-0036 Japanese 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates "natural", 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Target Co. Sales Rep Be permit. Page 1 and 2 should be fileo. Department of Health and Mental Himportant: If item 27 is meany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Seigil Murata Teruko Ikuno 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 8 5 3 19a. Informant's Name/Relationship (Type, Print) 30494 Valentine Drive, Princess Anne, MD Derwin Lowe 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2-2-2010 Crematory, Dover, DE 22. Name and Address of Facility 917 W. 21. Signature of funeral Service Licensee Isabella St. Bennie Smith Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septie Shock Gram Ph sician/ disease or condition resulting in death) Medical o (or as a consequence of): Examiner Concept penia Chamo Heropy Michican Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit mphomostous Meningritis that initiated events Due to (or as a consequence of) resulting in death) Last CATION APPROVED BY MEDICAL EXAMINER Paraplegio Completed by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 No 1 ☐ Yes ∠ 5 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital examiner? 1 X Yes 2.2 100 Hospital Other: Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Director: After Natural (Month, Day, Year) 5 Pending iniury Accident 1 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State 24 hours a Medical 29a. Certifier Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 17 Rev. 7/2009

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31. Date filed (Mont

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAWCIT P. KLUA, 100 E Colle 18 Fluid,

32 Registrar's Signatu

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Selisburg. mo.

JAN, 29, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** 2010 MARY R. MILLER 12 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Square Hospital If Under 24 Hrs. If Under 1 Year -6 Date of Birth (Month, Day, Year) /19/1951 5. Social Security Number L Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🖫 F Months Days 59 Maryland Director 216-52-8620 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exacting must be motified at angue. Darlington 1 ☐ Yes 2√ No Director MD Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21034 USA 3503 Hughes Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 → Married Baltimore, Maryland 21275-0036 1 ☐ Yes 2 ▼No White Specify: <u></u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and 2 should be i lealth and Mental Ruth Glassman Herman Beaman, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brenda Griffith/Daughter 3746 Dublin Road, Darlington, MD 21034 Pages 1 a Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 【 Removal from State Evans Eagle Crem. 2/12/2010 4 ☐ Donation 5 ☐ Other (Specify Leola, PA 21. Signature of Jurgeral Service Li 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA17314 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. L Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) embolisa **Physician** WIMOGORIL /Medical Due to (or as a consequency of Cancer Examiner east Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusity (or as a consequence of): Examiner sician and burial-transit that the death certificate be execute Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month Day Year 5 ☐ Other (specify) P.O. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an page 2 s has autopsy performed? /es 2 **A**No certificate 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the letely filled in by the funeral Medical Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

within 24 hours aft

To the Funeral Di

completely filled in To the within 2

> State Registrar

9000 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

John Kotthrathil

in Square Dr Baltimore

29d. Date signed (Month, Day, Year)

12,201C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** nna /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City. Town, or Location of Death Examiner Seasons Hospice
5. Social Security Number 6. Sex Randallstown
Inder 1 Year | If Under 24 Hrs. Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours Year) Months 1 □ M 2 □ F Director July 15,1976 NJ 136-70-5297 33 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantura must be inclined at 1 √2 Yes 2 □ No Director MD PG Oxon Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6419 Livingston Road 20745 United States Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. \$ 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 School System Supervisor permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othrany Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milton DeShields Joan Brooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12404 Old Fort Road
Fort Washington, Md

20b. Place of Disposition (Name of cemetery, crematory or other place) Robin Conquest/sister 20744 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory Riverdale, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 Part tenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or a / a consequence of) Examiner Sequentially list conditions, if an including Lambda late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed Due to (or as a consequence of) physician a s the burial-Box 68760, Physician/Medical attending pl IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 □Yes 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe Yes 2 page 2 🗆 No Division of Vital 1 □ Yes 1 ☐ Yes or Attending Physician: rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2/21/10 Other: 4 Nursing Home 5 Residence 6 Doth 1 ☐ Yes ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir er *(Spe* 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation Natural (Month, Day, Year) Injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) Medic and manner states 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

FEB 22 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 22:05 McDonough a harle Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 8. Date of Birth (Month, Day, g. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Days Min. 187-28-9708 Director Usual Residence of Decedent permit. Page 1 and 2 should le filled within 1/2 invariant. Page 1 and 2 should le filled within 1/2 invariant to Health and Mental Hygiene. The fillem 27 is illeared other than "natural", or items 23a or 28a-f show important: If item 27 is illeared other than "natural", or items 23a or 28a-f show important: If item 27 is illeared other than "natural", or items 23a or 28a-f show important if item 27 is illeared on the property of the property 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No nincoteague ccomack 10e. Street and Number 10g. Citizen of What Country? Funeral 23336 U.S. A 3481 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 👺No Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DQ NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Police Philadelphia Policeman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Charles Mc Donou aurette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) McDanayah sition Harion Main hincoteague VA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Exmore Jecohannock Crematory! 21. Signature of Funeral Service Licensee 22. Name and Address of Chincoteague, UA 23336 amanda C. Botto ver funcial Home unc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and resulting in death) Last attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Day Pregnant at time of death 1 Yes 2 No by the היושי עוווס seruticate has been signed ! funeral director, page 2 should be det. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has t autopsy performed Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 🗌 Yes မြ 1 Mainpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 🗆 Yes 2 🗆 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature D29283 on who completed cause of death (Item 23a) (Type, Print) 00 lar 31. Date filed (Month! Day, Year) State Registrar

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Physician/Medical

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Completed

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Medical Certification: To

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any hjury or other traumatic event, the Medical Examiner must be rediffied at once.

Physician /Medical

/Medical

Please	Type or Prir	nt in Black	< Ind	lelible Ink.	Ensure A	II Copie	es Are	Legit	ole.		
For State	State of Ma	-		rtment of He		√lental H	lygien	е			
Registrar			Cert	tificate of D)eath	1 - 5 - 1	Reg. No	·201	0	1194	
1. Decedent's Name (First, Middle, Las Anne L .	st) Moulton					2. Date of I			Year	3. Time of Deat Z 40 A	th M
4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, or l	Location of Death		4	c. County of		Z. 10 //	
C L 1 Haca	A+ The	104	•	Chel	1		1	100			
5. Social Security Number 6. S	iex 7. Ag	ge (In yrs. last birth	hday)		If Under 21 Hrs.	8. Date of E	Birth		9. Birthpl	lace (State or Fon	eign
214-32-6252	TM of the		Yrs.	Months Days	Hours Min.	02 27	Day, Year 7 193	r)	Count	vland	
Usual Residence of Decedent						02 2,	1200		1101	yrana	
10a. State 10b. County		10c. City, Town	or Loca	ation					10	0d. Inside City Lin	
Maryland Wicomi	.co	Parson	nsbı	ırg						1 □ Yes 2 🕱	No
10e. Street and Number				10f. Zip Code			10g. C	itizen of Wh	nat Coun	try?	
7130 Parsonsburg	Road			21849	ı		I	USA			
11. Marital Status	12. Was Decedent B Armed Forces?	Ever in U.S.	13. W	as Decedent of His Yes, specify Cuban	spanic Origin? (Sp	pecify Yes or	No-			an Indian,	
1 ☐ Never Married 2X Married	1					Mican, etc.,			, White, e		
3 Widowed 4 Divorced	If Yes, Give Year or Dates:		"	□Yes 2☐No	Specify:			Specify:	wh	nite	
15. Decedent's Ed (Specify only highest grad	lucation			ent's Usual Occupat		-in-	16b. l	Kind of Busi	iness/Ind	lustry	
Elementary/Secondary (0-12)	College (1-4or 5		life. DC	ina of work done at O NOT use retired)	ITING THOSE OF WORK	ing					-
12	2		ookk	keeper			S	nore J	Dist	ributors	
17. Father's Name (First, Middle, Last) William George Wh					18. Mother's Name Mary E.	e (First, Midd 11en R	lle, Maidei lobin:	n Surname, SON)		
19a. Informant's Name/Relationship (7	Type. Print)	19b.	Mailing	Address (Street ar	nd Number or Rur	ral Route Nur	mber, City	or Town, S	State, Zip	Code)	- 1
Donald Moulton s	pouse	7.	130	Parsonsb	urg Rd.,	Parsc	nsbu	rg, M	D 218	849	
20a. Method of Disposition		20b. Place of I	Disposi	tion (Name of		Date	20c. I	Location - C	City or To	wn, State	
1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	y)	Jerusa Cemete	lem ery	atory or other place.	2 4 .		Par	rsons	burg.	, MD	
21. Signature of Funeral Service Licens	Dan	L	Ho]	Name and Address Illoway Fu I Snow Hi	neral Ho	me Pro Salisk	fess:	ional MD 2	Asso 1804	ociation	
23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death. Do no	ot enter	the mode of dying	, such as cardiac	or respiratory	y arrest,	Product 1		Approximate Interval Between	
Immediate Cause (Final	50	0 54	1	The me	no the	D f.	- lun	Dear	450	Onset and Death	
disease or condition resulting in death)	a. Due to (or as	a consequence of	f):	wurme !	10711HU	West In	UTACS A	-	2	near	1
	200 10 (0. 22 .	a consequence.	1.								
Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of	n):								
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			,.								
that initiated events resulting in death) Last	c	a consequence of	f):								
	Dac 10 (0	1 0011009101101	,.								
	.d										
IF FEMALE:									-		
23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pregnancy			1	23d. Date			
1 ☐ Yes 2 ☑ No	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)			-	Mont	h i	Day Year	
9 ☐ Unknown	JU CIMION.										
Part II. Other significant conditions co	ontributing to death bu	ut not resulting in f	the und	erlying cause giver	ı in Part I.	23e. Di	d tobacco	use contrib	oute to the	e cause of death?	,
						1[☐Yes 2	2 □ No 3	3∏ Proba	ably 4 🗷 Unkno	own
						24a. Wa	ae an	Tah W	ore sutor	ney findings avails	hla
						aut	itopsy erformed?	pri	rior to con	psy findings availa npletion of cause	of
							s 2 10 N	0 1[∐Yes	2 N o	
25. Was case referred to medical examiner?	Hospital:				26. Place of Death	h (Check only	y one)				
1 les 2 pa 140	1 L Inpatie				4 LI Nursing Ho	ome 5 ☐ Re	esidence	6 🗷 Other	r (Specify	Hospie	<u>-</u>
27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injui (Month, Day	ıry 28b. Tir y, <i>Year)</i> İnj	ime of jury	28c. Injury : Work?	at	28d. Describ	e how inju	iry occurred	t	,	
2 ☐ Accident investigation					es 2□No						
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju-	ury - At home, farn c. (Specify)	n, stree	t, factory, office		28f. Location	n (Street a	nd Number	r or Rural	l Route Number,	

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bundartransit Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one) 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

01-30-10 D 29505

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BELLOSO, M.D.: 5302 CHINABERRY DR., SALISBURY, MD 2180)
32. Jegistrar's Signature GREGORIO

State Registrar

31. Date filed (Month, Day, Year)
FEB 0 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month AV Physician/ McIntyre Hazel Margaret 1015 2010 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Kegional Medical NICOMICO Sbyly If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months 218-20-7198 Hours Min. **Director** 82 05 26 1927 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Wicomico Maryland Salisburv 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 519 Winder St 21801 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced white Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) housewife domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gordy Robinson Elizabeth Augusta Seward 19a. Informant's Name/Relationship (Type, Print)
Ralph McIntyre, Sr spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 519 Winder St., Salisbury, MD 21801 permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 2 6 10 Salisbury, MD 21. Signature of Funeral Service Licer Name and Address of Facility HOIIOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Wet! 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month signed by the a 2 🗆 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed this certificate has been s ral director, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No Yes 2 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 2 No 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA After thi funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. al Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ritiving Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one re and title 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 100 G. CAYOI

32 Registrar's Signatur

SAUSbury

30. Name and address of person who completed cause of death (Item 23a) (Type,

50404

Chiis 31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 2010 Robert Kenneth McKissick anvar 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Plata Medica La rar ivista Conter If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Year Min. 1፟፟፟፟∭ M 2□ F Months Days Hours July 9, Washington D.C. 577-46-3267 1935 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Waldorf Charles Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20601 United States 11619 Kipling Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ▼ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No White Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Southland Dairy 10 Machine Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Ork McKissick Rubie McKenney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11619 Kipling Drive, Waldorf, Maryland 20601 James L. McKissick/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nomini Baptist Church 2-5-2010 Montross, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility 211 St. Mary's Ave Arehart-Echols Funeral Home, P.A. LaPlata, MD M01458 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STROINTESTINAL 551 en HR disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes

Physician /Medical Examiner

Physician

Examiner

Director

Funeral

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Maricial Example 23 or 2016 any Injury or other traumatic event, the Maricial Example 23.

Baltimore, Maryland 21215-0036

/Medical

Examiner certificate be executed

burial-transit and attending physician as the for use been signed by the should be detached

Box 68760.

P.O.

Division of Vital Records,

After this certificate has

Physician/Medical δ Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be ည filled in by the funeral Certification: Medical

> State Registrar

29b. Signature and the of certifier

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

XHERIM CIVERA

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

POST OFFICELD WANDORF MD

28d. Describe how injury occurred

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

2010

20602

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUMJE

Hospital:

5 ☐ Pending investigation

6 ☐ Could not be

determined

28a. Date of Injury (Month, Day, Year)

31. Date filed (Month, Day, Year)

FLB 0 5 2010

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1-For State Amend I tems Registrar		epartment of Sa-f per Certificate o	f Health and Peath 25,	d Mental 2172	Hygiene -	Reg. No. 20	10 0494
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last —	•				2. Date of De Month		3. Time of Death
	Conray Lee Mod 4a. Facility Name (if not institution, giv	e street and number)		4b. City, Town, or	Location of De	Month January	18, 2010 4c. County of	0935 hrs
	419 Dominion Road	o otrost aria riambor,		Chester	Education of De	201	Queen Ar	
Funeral	5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday)	If Under 1 Yea	ar If Under 24	Irs. 8. Date of 8		Birthplace (State or
Director	214-66-8699	M 2□F 53	Yr	Months Day	s Hours N			Foreign Country) VA
	Usual Residence of Decedent					1		
ct .	10a. State 10b. County MD Queen		City, Town or Loca	tion				10d. Inside City Limits
Maryland 28a-f show 1 at once.	243011	Annes	Chester					1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number 419 Dominion F	, a		10f. Zip Code			10g. Citizen of Wha	t Country?
23a o				21619			USA	
or items 23	11. Marital Status 1 X Never Married 2 Married		If Y	as Decedent of His res, specify Cubar			o- 14. Race - White,	American Indian, Black, etc.
ter de	3 Widowed 4 Divorced	1 Yes 2XX	No 1	Yes 2XX No	specify:		Specify:B	lack
hours afte "natural", Examiner ted by	15. Decedent's Education (Specify or	or Dates: nly highest grade complet		nt's Usual Occupat	tion (Give kind o		16b. Kind of Busin	
6 72 ho 12 le le le le le le le le le le le le le	Elementary/Secondary (0-12)	College (1-4 or 5+)		ost of working life.	. DO NOT use r	etired)		
5-0036 ed within 72 hour tygiene. other than "natt the Medical Exat	12		Land	lscaper			Self-er	mployed
15-(filed 1 Hyg of oth t, the	 Father's Name (First, Middle, Last) Noah Moore 						Maiden Surname)	
21215-0036 total by given the Medica in the Medica in the Medica in the Medica in the Medica IO Be Comple	19a. Informant's Name/Relationship (T	vpe, Print)	19b. Mailin	Address (Stree		Gidden	mber, City or Town,	State Zie Code)
		sister)					ster, MI	
Te, L	20a. Method of Disposition		20b. Place of Dispos crematory or ot	ition (Name of cer		Date	20c. Location - C	
Baltimore, permit. Pages I an Department of He Important: If ite njury or other tr	1 Surial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State	Union We	sley Ce	em 1,	/23/10	Chester	r MD
alti mit. partm ports iury o	21. Signature of Funeral Service Licen	see	22. N	lame and Address	of Facility		Dover	DF
1 1	Jammie U.S	shaw	B€	nnie Sm	nith F	1 717 W	Dover Divis	ion st
Physician /2 /Medical	23a. Part I. Enter the disease, r compfailure. List only one cause on ea	ch line.						Approximate Interval Between Onset and
Examiner	and the second s	Hypertensive Ather		ovascular Dis	ease com	plicated	by Hypot	hermia Death
		Due to (or as a consequer	nce of):					
ner	Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause	Oue to (or as a consequer	nce of):					
E (Disease or injury that initiated C.	Oue to (or as a consequer	nce of):					
	d		,					
e be executed ysician and burial - transi	UNPENDED	AMENDED	.			-		
	F FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcome of	pregnancy				23d. Date of de	livery
ox 6876(eath certificate eath certificate attending phys for use as the b sician/Me	past 12 months?	1 Live birth 4 Pregnant at time	of death	tal death 3 L	Ectopic pregr	nancy	Month	Day Year
	1 Yes 2 No 9 Unknown	9 Unknown	3 Oti	ner (Specify)				
n of Vital Records, P.O. Eding Physician: The law requires that the the After this certificate has been signed by the funeral director, page 2 should be detached on: To Be Completed by Physics and the state of the	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause gi	iven in Part I.			te to the cause of death?
- s 50 s -						1 Yes	s 2 🗸 No 3	Probably 4 Unknown
ord w req as bee ? shou		·				24a. Was autop		re autopsy findings available r to completion of cause of
Records, The law require ficate has been signage 2 should be							rmed? dear 2 ✓ No 1	th? Yes 2 No
ician: certifi ector,	Was case referred to medical examiner?	ospital:			of Death (Check	only one)		
Physical direction of the second of the seco	1 Yes 2 No 7. Manner of Death	I Inpatient 2	-				Residence 6	Other: Scene
Division of Vital Records, all or Attending Physician: The law requires after death. al Director: After this certificate has been si led in by the finneral director, page 2 should bartification: To Be Completed artification: To Be Completed	Natural 5 Pending	28a. Date of Injury Format Pay, Year)	28b. Time of Ir		yatWork? es 2∑No	Subject	how injury occurred exposed	
isior Attend er death. rector: by the ficatio	2 X Accident Investigatio	28e Place of Injuny -	7.234.1	11 •				mperatures. r Rural Route Number, City
Division o spital or Attending nours after death. In meral Director: After filled in by the fine Certification:	determined	(Specify) Home		, , , , , , , , , , , , , , , , , , , ,		or Town, S Chester	tate) 419 Doi	minion Road
	9a Certifier 1 Certifying Physicia	n: To the best of my know	wledge, death occurr	ed at the time, dat	e and place, an	d due to the caus	e(s) and manner as	stated.
To the Hos within 24 h To the Fur completely	ne) 2 Medical Examiner:	On the basis of examination of the basis of examination of the basis o	on and/or investigati	on, in my opinion,	death occurred	at the time, date	and place, and due	to the cause(s)
5° 2 °	9b Signature and title of certifier	ONA.	ADOU	29c. License			29d. Date signed	(Month, Day, Year)
	Jielo Valler	4 sel		O.C.M	1.E.		January 20, 2	010
n.5 30	30. Name and address of person who completed cause of death (Item 23a)							
1 1	10. 10.	sistant Madical Eva	minor 111 D	onn Circot D	dimer- **	21204		
State ³¹	10. 10.	sistant Medical Exa		enn Street, Ba	altimore, MD	21201		

OCME

10-00846 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Glen Anthony Maffia State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death 3. Time of Death Medical Examiner GLEN ANTHONY MAFFIA 1450 hrs January 29, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 304 Mill Pond Lane Apt. 237 Salisbury Wicomico 5. Social Security Number If Under 1 Year 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) If Under 24Hrs. Foreign Mineola, Days Hours Director Months 8/5/1970 091-50-2703 39 1 X M ŃΫ Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Townsend DE New Castle 1 Yes 2 X No 28a-f show tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho. or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 609 Southerness Drive 19734 USA Funeral 11 Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married White, etc. 2 Married 1 Yes 2XX No timore, MD 21215-0036

1. Pages I and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. White Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year Specify ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 3 Crew Chief Racing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Linda Sue Vascellaro Frank Maffia Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Frank & Linda Maffia/Parents 609 Southerness Drive, Townsend, 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition Baltimore, 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 XX remation 3 Removal from State crematory or other place) 2/3/2010 United Crematory Newark, DE 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DANIELS & HUTCHISON FUNERAL HOME

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

Applications of Pacility

DANIELS & HUTCHISON FUNERAL HOME

1212 N. Broad Street, Middletown,

Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

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Applic Annroximate Interva Physician failure. List only one cause on each line Between Onset and /Medical Contact shotgun wound of head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the burial - trans Physician/Medical AMENDED 23a,27,28a-f,permE, g901 3/8/10 TT Y UNPENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Day Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown by the a signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 2 1 Yes 2 No 3 Probably 4 V Unknown Completed certificate has been sector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? page ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medica 26.Place of Death (Check only one) æ Other₄ this Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene ဥ 1 V Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Natural 1 Yes 2 X No subject shot self 1/29/10 Fd 2:50 pm 2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 X Suicide Could not be or Town, State 304 Mill Pond Ln. Apt 237 Salisbury, MD determined private dwelling 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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State

29b. Signature and title of certifier

31 Date filed (Month, Day Year)

Ling Li, MD

mi. ms

30 Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

29c. License numbe

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 30, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10d & 10e per FH g901 3/3/10 TT

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **2**, **Physician** Charlotte Cranston Miller February 2010 5:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2707 Riva Road Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1/21/1919 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
____ **Funeral** 224-60-9561 1 □ M 2 🔀 F Months Days Hours Min 91 Director Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Modeal Examinar must be notified at Maryland Anne Arundel Annapolis 1 1 1 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41 Cornhill Street 2660 Pemaquid Ct. 21401 USA 'natural", or items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a and Injury or other traumatic event, the Medical Examiner mass 1 once. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White 3 Nidowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cryptanalyst NSA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Joseph Cranston Helen Irene May မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Smith - Cousin 41 Cornhill St., Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Gardens 2/8/2010 Arlington, VA 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee Myelin T. Klober 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimers Dementia Physician disease or condition resulting in death) 4 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dise to for sels noneequance of: The law requires that the death certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical After this certificate has been signed by the attending pruneral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death' 2 No 1 ☐ Yes 2 🖫 📶 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident death. 1 ☐Yes 2 ☐ No the within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospitai 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Pr Bostgate Rd. Annapolis, Md. 2140/ E. selouide 900

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 04 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

hn Bosco C	Owe		State of Maryland / D	epartment Certificate			d Men	tal Hy	_	Reg. No	20	0	0494
Physi	icia	n/	Registrar 1. Decedent's Name (First, Middle,Last)					T	2. Date of De	ath		3	3. Time of Death
edical Exa	min	er	JOHN BOSCO OWENS		T 4	o. City, Town, or	Lagation	of Death	Month February			Da ath	1600 hrs
			Facility Name (if not institution, give street and number) 18108 Piedmont Drive		41	Cobb Island		or Death			c. County of I Charles	Death	
Funer	al		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)		If Under 1 Yea		er 24Hrs.	8. Date of B	irth (MM			olace (State or
Directo	or	ı	215-36-3988 Ж м ₂□F	68	Yrs.	Months Day	s Hours	Min.	6-11	1-19	941	oreign Coun	atry) MD.
,		İ	Usual Residence of Decedent 10a, State 10b, County 10c,	City, Town or Lo	ontio							- 14	Od. Inside City Limits
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Maryland 28a-f show any	at onc	Director	10e. Street and Number			10f. Zip Code				10g. Cit	tizen of What		
the M	tified	盲	18108 PIEDMONT DRIVE			2062	25			U.S	S.A.		
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urs afte	amine	희	3 Widowed 4 Divorced If Yes, Give Year 9 5 9. 15. Decedent's Education (Specify only highest grade complete	-6.3 1 1 deced		Yes 2 X No		kind of wo	ork done	16b.	Specify: W] Kind of Busir		
72 hou	al Exs	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			st of working life			•	1_			
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21215-0036 buld be filed within 7 Mental Hygiene.	t, the	ادہ	17. Father's Name (First, Middle, Last) WILLIAM E • OWENS						First, Middle,	Maider	n Surname)		
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho	ic ever		19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling /	Address (Stree			OWNS ural Route Nu	ımber, C	City or Town,	State, Z	ip Code)
MD id 2 sho llth and in 27 is	anmat		BILLY OWENS-SON	259	RI	ED CLOU	JD RI	D.			206		
or Heal	her tr		1 X Burial 2 Cremation 3 Removal from State	20b, Place of Disp crematory or	othe	r place)			Date		Location - C	•	
Baltimore, permit. Pages 1 ar Department of Hee important: If ite	y or of		4 Bonation 5 Other Specify.	MD.VETE							CHELTI	ENH.	AM,MD
Bal permi Depar Impo	injur		21. Signature of Funeral Service Licensee M00479	P	A)	me and Address MOND F PLATA	UNEF	, RAL RAL	SERVI	ÇE,	P.A.		
Physicia	ın	1	23a. Part I. Enter the disease, or complications that caused the diffillure. List only one cause on each line.								ock, or heart		Approximate Interval Between Onset and
/Medica			Immediate Cause (Final disease a. Gunshot Wound of	Chest Con	tae	ct gunsh	ot w	ound	of ch	est			Death
			or condition resulting in death) Due to (or as a consequer	nce of):									
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	nce of):			-						
		Examiner	Coisease or injury that initiated events resulting in death) Last	nce of):								+	
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Box 6876(death certificate the attending phy:	as the t	ŽΙ	IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 Live birth	pregnancy		I death 3	_	: pregnan	су	23	d. Date of de Month	livery Day	y Year
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O. But the de	었 .	Physicia	Part II. Other significant conditions contributing to death but	not resulting in the	e un	derlying cause g	iven in Par	rt I.	23e. Did t	tobacco	use contribu	te to the	e cause of death?
F. P.O.	be det	힐							1 Ye	s 2 •	/ No 3	Probab	oly 4 Unknown
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of Vital ng Physician: After this certi	큔 I	의	1 Yes 2 No Hospital: 1 Inpatient 2 7. Manner of Death 28a. Date of Injury	2 ER/Outpatie			Other ₄		Home 5	,	ence 6 🗹	Other: S	cene
on of nding Pl tth.	ne funeral		1 Natural 5 Pending FOUND: Day, Year)	FOUND:	, my		es 2	19	ubject sho				
Division tal or Attendin safter death.	n by the	fical	2 Accident Investigation Feb 13, 2010 3 ✓ Suicide 6 Could not be 28e. Place of Injury -	1445 hrs At home, farm, st	reet,	factory, office be	uilding, etc	c. 2			and Number o	or Rural	Route Number, City
Divinal of ours at ours at	filled in	Certification:	4 Homicide determined (Specify) Single	Family Resid	enc	e		18	or Town, 1 8108 Piedm	State) iont Dri	ive, Cobb Is	sland, I	MD
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy	~	- 1	29a Certifier 1 Certifying Physician: To the best of my known one) 2 Medical Examiner: On the basis of examinating										:ause(s)
To t with To t	com	Medical	and manner stated 29b. Signature and title of certifier	7 100	1	29c. License			are une, date		Date signed		
			1/18/2 1/10 /les	1 mon	50	O.C.N	Л.E.				oruary 14,		
140		ł	30 Name and address of person who completed cause of death ((Item 23a)									
di,			Victor Weedn MD JD Assistant Medical Exa		Pe	nn Street, B	altimore	, MD 2	1201				
Reg	Sta	-	32. Registrar's Sig		,								

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alexandra Osequeda-Figueroa Lumi Month 20[']10 p^{M} January 1:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico 36392 Hearn Street Willards Social Security Number 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min 1 M 2 X F Months 1211412009 213-87-1935 Director Yrs. Marvland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🔀 Yes 2 🗌 No Wicomico Willards Maryland 10e. Street and Number ō 10f. Zip Code 10q. Citizen of What Country? Funeral items 23a 36392 Hearn Street 21874 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rigan, etc.) ElSalvador 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ö 1 Never Married 2 Married þ 2 X No Maryland 21215-0036 1 X Yes 2 ☐ No If Yes, Give Year or Dates Puerto Rican "natural", Specify: spanish | latin 3 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) nla n|a traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Alexander Figueroa Ana Osequeda permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36392 Hearn St., Willards, MD 21874 Alexander Figueroa father Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Salisbury Crematory 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1 29 10 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service, Licensee 2. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (* r as a consequer ce of) disease or condition Medical resulting in death) seuse, PDA, courcitation, ASD Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Exam Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last risomy and Due to (or as a consequence of) attending physiciar Physician/Medical Box 68760 the as for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached f the 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed certificate 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 🗌 Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 1 X Natural 5 Pendina work? 1 🗌 Yes 2 🔲 No 24 hours at er death Funeral Director A Accident Investigation the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 the only one 29b. Signa re and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nd address of person who completed cause of death/(Item 23a) (Type, Print) Wehberg, Jebhifer 4. MD 106 Milford St., Salisbury, MD 21804 31. Date filed (Month 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2220 2010 Medical chruan 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford pper Chesapeake Medica (enter Marylun Bel Air 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 № M 2 🗆 F 3 / 1 9 / 1 9 4 1 Director 218-40-8549 68 Usual Residence of Decedent 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified MD Harford 1 Yes 2 X No Bel Air 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2116 Robertson Road 21014 USA items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Unknown
Year or Dates. Black, White, etc. 0 þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural", Specify: White Completed 3 - Widowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Concrete Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Puckett Zita Halsev Department of Health and Important: If item 27 is m. any injury or other traums once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Puckett/Brother 250 Wheeler School Road, Pylesville, MD21132 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Darlington Cem. 2/18/2010 Darlington, MD 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ^onysician/ Myocardial Infantion

Due ti (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 2 No the Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 perform 25. Was case referred to medica funeral director, æ 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes မြ 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at s after death. I Director, After t 1 Natural 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a To the Funeral D Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatur ertifie 29c. License number February 15, 2010 sooypredhesupeake Drive

Registrar

State

Medical Ductur; Upper Moscycallo Emergeny Department; Bel Air, Maryland 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

wrence Mure (delmus

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yea 0046 **Physician** 3,2010 Marion Inez Pulliam February /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's

9. Birthplace (State or Foreign Prince George's Hospital Center Cheverly
Ider | Year | If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 08/05/1954 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Virginia Days Hours Min. **Funeral** Months 1 □ M 2 🗓 F 55 Director 226 84 4241 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10a State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Modical Examinar marks in citized at 1□Yes 2□No Prince George's Bladensburg Director MD 10g. Citizen of What Country? 10e. Street and Number 20710 US 5638 Emerson Street Apt B8 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2□ No If Yes, Give Year or Dates: Specify: Black 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MovingCompany Driver 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Morton Pulliam Willie Nash ڡ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2094 Pilgrim Dr Woodbridge, VA 22192 Jermaine Jackson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Pages Department of important: If Its any injury or o Luke Bapt Ch. Cem 2/11/10 Skipworth, VA

22. Name and Address of Facility C.H. Harris Funeral Home 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licensee P.O. Box 745 Clarksville, VA 23927 2 Mikely 902 scolone Approximate Interval Between Onset and Death 23a. P. 11. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner way Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (as a consequence of): Examine The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery ves, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 NO certificate l 1 ☐ Yes 2/KINO 1 ☐ Yes Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death or Attending 1. Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after death Funeral Director: the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide filled in by determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely within 2

RBUL 10

State Registrar

ames 31. Date filed (Month, Day, Year) FEB 0 4

29b. Signature and title of certifier

30. Name and

Registrar's Signature 32

ddress of person who completed cause of death (Item 23a) (Type, Print)

2010

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State		artment of Health tificate of Death		Hygiene	
			Registrar 1. Decedent's Name (First, Middle, Last)	10 10 495 1				
	Physicia Medic		FLEETA LORRAINE PASSON	Year 09:45 P M				
providen.	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location	JANI of Death	JARY 29, 20 4c. County o	
1			2014 GOVERNOR THOMAS BLADEN		ANNAP			ARUNDEL
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🔏 F 7. Age	e (In yrs. last birthday) 86 Yrs.	If Under 1 Year If Under 1 Months Days Hours	r 24 Hrs. 8. Date of Min. (Month	f Birth 1. Day, Year) 16, 1923	Birthplace (State or Foreign Country) MISSOURI
			Usual Residence of Decedent	00		MAI	10, 1923	MISSOURI
	land f shor	ţō	10a. State 10b. County	10c. City, Town or Loc	cation			10d. Inside City Limits
	Many 28a-	Director	MARYLAND ANNE ARUNDEL		ANNAPO	LIS		1 🗌 Yes 2 🗶 No
	ith the	la [10e. Street and Number	* **** #100	10f. Zip Code		10g. Citizen of Wi	nat Country?
	ath w	Funeral	2014 GOVERNOR THOMAS BLADEN 11. Marital Status 12. Was Decedent E		Vas Decedent of Hispanic O			D STATES
9	or ite	by F	Armed Forces? 1 □ Never Married 2 🗶 Married 1 □ Yes 2 🛣	No.	Yes, specify Cuban, Mexica	ın, Puerto Rican, etc.	1 11 7 10000	- American Indian, , White, etc.
003	ursafi urali", IExa		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	Yes 2 No Specif	<i>/</i> :	Specify:	WHITE
15-(within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occupation kind of work done during mo	st of working	16b. Kind of Bus	iness Industry
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/lar	d be f Menta arked itic ev	2	ERNEST DELMAR WOOLERY		OLI	LIE BELLE	WHITTLE	
Maryland 21215-0036	should be file and Mental 7 is marked or raumatic eve		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Numb			ite, Zip Code) 21401
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 2be notified at other traumatic event, the Medical Examiner must be notified at		ROBERT D. PASSON/HUSBAND			AS BLADEN	WAY,#102,	ANNAPOLIS, MD
altimore,	nt of h		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos	untonument of headrace)	EBRUARY 2	20c. Location - C	city or Town, State
ij.	permit. Page 1 Department of Important: If i any injury or conce.		4 Donation 5 N Other (Specific NTOMBMENT 21. Signature of Funeral Service) icensee	PARK MAUS	OLEUM :	201	ANNAPOT T	S. MARYLAND
Ba	Dep any	1	911:11 72/2	00672 CŔ	Name and Address of Facil EMATION AND I AD, ANNAPOLIS	UNERAL CA	RE, P.A., S	814 BESTGATE
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.	the death. Do not ente				Approximate
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-	Medical Examiner		The state of the s	consequence of):				7 7 7 7 7
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387	rtifica ling ph	/Me	IF FEMALE:					
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Ď.	he deg	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown	time of death 5	Other (specify)			Tour
Division of Vital Records, P.O.	that the	by PI	Part II. Other significant conditions contributing to death but	_			lid tobacco use contrib	ute to the cause of death?
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COL	aw rec as be 2 sho	Completed	Arthritis, UTE	ent 4	AN CER	24a. V		ere autopsy findings available or to completion of cause of
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ţa	ician; certific ector,	0	25. Was case referred to madical examiner?			ath (Check only one)		
> >	Phys	은	1 ☐ Yes 2 ☐ No 1 ☐ Inpatie 27. Manna of Death 28a. Date of injun	nt 2 ER/Outpatient 28b. Time of	Other: 4 N		lesidence 6 Other	(Specify)
o uc	nding ath. :: Afte e fune	cate	1 ☑ Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident Investigation		work? M 1 1 Yes 2		be how injury occurred	
isic	r Atter	Certificate:	3 Suicide 6 Could not be 28e. Place of Injur	y - At home, farm, stre	et, factory, office		on (Street and Number of	or Rural Route Number,
<u>S</u>	ital or Insaft ral Dir		building, etc.				Town, State)	9
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifler (Check 2 Medical Examiner: On the basis of examiner)	amination and/or investi	gation, in my opinion, death c	ccurred at the time, da	ite and place, and due to	the cause(s) and manner stated.
	io the vithin of the omple	ž	only one) 3 Certifying Nurse Practioner: To the b 29b. Signature and title of certifier	est of my knowledge, de	eath occurred at the time, dat 29c. License number	e and place, and due t	o the cause(s) and mann 29d, Date signed (f	er as stated.
	1///		> Stephin 14	Kat,	0386	87	Febru	
	XM		30. Name and address of person who completed cause of de-	ath (Item 20a) (Type, Pr			1	- / -/
	4		STEPHEN KATZ, M.D., 31 ROB		, SEVERNA PAR	K, MARYLA	ND 21146	
	State Registra	e	31. Date filed (Month Day Year) 3 2010 32. Registrar	's Signature	and b			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** FEBRUARY 3, 2010 1:55 A EDWARD TERRY PERKINS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner DENTON

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Venths Days Hours Min. AUGUST 3,1925 CAROLINE CAROLINE NURSING & REHAB CENTER 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 XM 2□ F MARYLAND 84 Director 217-36-0674 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County ral, or items 23a or 28a-f ahow Examiner must be collified at 1X Yes 2 No Director WYE MILLS MD TALBOT 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 21679 USA 14176 OLD WYE MILLS ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No "natural", or Specify: If Yes, Give Year or Dates: by WHITE 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) QUEEN ANNE COUNTY ROADS TRUCK DRIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be fund Mental It and Mental BLANCHE KINNAMON PAUL PERKINS ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2
Department of Health ar
Important: If Item 27 Is
any Injury or other free... P.O. BOX 136, CORDOVA, MD 21625 ROSE MARIE ANDREW/ DAUGHTER Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition CHESAPEAKE CREMATION CENTER 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 2-4-2010 STEVENSVILLE, MD ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Momar K. Saller 408 S. LIBERTY ST., CENTREVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the design of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death Month Day jo in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No detached 9 Dinknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pp 2 No 3 Probably 4 Unknown 1 🗌 Yes been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has page 2 certificate 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) director Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 3 DOA 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28c. injury at Work? filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury or Attending 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 \ Homicide within 24 hours after To the Funeral Dira To the Hospital 😭 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifies Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

32. Registrar's Signature

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2°, 2010° 6:30 PM Louise Bagloni Rakich Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick 3429 Tudor Drive Adamstown Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🖾 F Months Hours Min. Nowhith, Pay, Year 1930 Pennsylvania 179-24-9983 **Director** 79 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location with the Maryland must be notified at Director 1 Yes 2 No Adamstown Maryland Frederick 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a injury or other traumatic event, the Medical Examiner must b Funeral United States 21710 3429 Tudor Drive Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give altimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Grocery Plant Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clara Fox Marsilio Bagloni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 3429 Tudor Dr. Adamstown, MD 21710 Joseph Rakich / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or of once. cametay, crematory or other place) Holy Trinity Orthodox Cemetery Feb. 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Horsehead, New York 22 Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 Signature of Function Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Advanced Dementia vears Medical Due to (or as a consequence of) Examiner <u>Anorexia</u> year Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury Parkinson's Disease years that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Failure to Thrive weeks Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death signed by the at d be detached fo ☐ Yes 2 😾 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 🔀 No 4 Nursing Home 5 X Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a, Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 K Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifie 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gentlying Nurse Pragrence To the country knowledge, death occurred at the time, date and place, and due to the reuse(s) and manner as stated. (Check Gertifying Nurse Pragitymen T. II 29b. Signature and t 29c. License number 29d. Date signed (Month, Day, Year) February 4, 2010 D 54749

State Registrar Allen Reilly, M.D. 801 Toll House Ave., Frederick, MD 21701

91 32. Registre 's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ nomas var 30 PM 2010 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death salisbur ice 0 ICOMICO If Under 1 Year 7. Age (In vrs. last birthday If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 X M 2 D F Months Min. (Month, Day, Y July 8, 1 Director Yrs 221-58-1293 1964 Pennsylvania Usual Residence of Decedent 10a. State 10b. County with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits DE 1 ☐ Yes 2XX No Sussex Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 32725 Bi-State Blvd. 19956 U.S.A. hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No 1982If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced 1986 white Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 21215-16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Supervisor Pest Control Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ဨ pe John W. Sullivan Catherine Metrules permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Melvin (Sister) 908 E. Grove Street Delmar, DE 19940 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State Stephens Cemetery Feb. 1, 2010 Delmar, Delaware 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Name and Address of Facility

Short Funeral Home <u> 13 East Grove Street</u> Delmar, DE . Part 1. Enter the disease, ox complication shock, or heart failure. List only one cau s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ CIRRIHDSIS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 No signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes Probably 4 ☐ Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ျှ 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I HOSPICIZ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending ☐ Accident ☐ Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 10058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOX rom

State Registrar 31. Date filed (Mont

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** <u>6:</u>30 ^{A м} Lankford Smith 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Home & Heart Elderly Care Quantico Wicomico | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖾 F Director 212-16**-**1171 90 -5 - 1920Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic event, the Medical Examinar must be notified at 1 X Yes 2 □ No Director MD Wicomico Quantico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 21856 USA Funeral 6442 Quantico Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. 1 □ Never Married 2 □ Married 21215-0036 Specify: White "natural", or 1 ☐ Yes 2 X No Specify: Completed by If Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Florist Flower Shop i and Mental Hygi Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Windsor ၀ Lankford Mable 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trau 9826 Sharptown Road, Mardela Springs, MD 21837 Scott L. Smith - Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-3-2010 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 21. Signature of Funeral, Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCUID **Physician** : /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □Yes 2 ☑No 1 ☐ Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 🗹 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide filled 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier vh 347694 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) · ND 21804 5. DIVISION Shock 57L 15BU 04 +TESA2 1415 gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Liscum Sr. Serviss Month Year 03/2 JAN 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Age (In yrs. 86 If Unde 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 091-16-2911 Months 1 🔀 M 2 🗆 F Hours Min. 041 New York **Director** Usual Residence of Decedent ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗓 Yes 2 □ No Maryland Salisbury Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21.804 Funeral 1110 Healthway Dr., Suite 253 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 1 2 Yes 2 1 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 X Married Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Divorced Year or Dates Army Specify: white permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important; If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) assistant state comptroller state government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harold Serviss Ruth Liscum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1110 Healthway Dr., Suite 253, Salisbury, MD21804 Elizabeth Serviss|spouse Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 2 3 10 Salisbury, MD Signature of Funeral Service Licensee 22.Name and Address of Facility Holloway Funeral Home Professional Association CESP Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant a
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1. Natural 5 \square Pending 2 🗆 No Accident
Suicide
Homicide Investigation Director; 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours after To the Funeral Dire City or Town, State) Medical Leave Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowing and a character of the time, date and place, and due to the cause(s) and manner as tated. (Check 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 77875000 1 N.W 30. Name and address of person completed cause of death (Item 23a) (Type, Print) DIVIDIUM 11

Registrar

State

31. Date filed (Month)

05

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 14 per DVR G900 2/22/10 dk.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Year /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner altimore Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. | 8 al Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Months Days 1 □ M 2 □ unknown Yrs. Director 1ary Jana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be notified at Baltimore isterstou Director 1 ☐ Yes 2 ☐ ¥6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò lanor 'natural", or items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of the fealth and Mental Hygiene.
Int. If item 27 Is marked other than "natural", or itel 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 PYes 2 □ No Specify: C-Ua ta Maki þ 3 ☐ Widowed 4 ☐ Divorced Specify: unknown Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be CCUM ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wlanor Load Shirle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ■ Other (Specify) ☐ Other (Specify) ☐ Other (Specify) ☐ Other (Specify) ☐ Other ☐ Othe 3 10 tOSDITAL 22. Name and Address of Facility HOSPITAL 240, W. Belveree Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): P.O. Box 68760, cate has been signed by the attending p page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) Inci 9 Onknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2/1 No 3 Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 No 1 □Yes 2 **N**O 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29b. Signature and title of gertifie 29c. License number 29d. Date signed (Month, Day, Year) NPI 163135) 899 1201 C Mil anla 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belvedere Avenue tasha M.I 2401 Baltimore, MD 21215 31. Date filed (Month, Day, Registrar Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician Sheila J. Touhey 1:25 PΜ 23 2010 Jan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Talbot Genesis HealthCare -The Pines Easton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 💢 F 186-20-3065 Director 3/11/1926 Whales 83 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 27 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Modical Examiner must be nothed at 1 TXYes 2 □ No Directo MD Talbot Easton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral 21601 USA 610 Dutchman's Lane 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ No Specify: Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk/Supervisor Dept._of Social_Serv. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ Thomas Edward Jones Lillian Simpson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Almon C. Barrell/Guardian through permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai 100 Schauber Rd. Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/25/10 Chesapeake Cremation Stevensville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ned by the a 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1.7.5.10 Name and address of person who completed cause of death (Item 23a) (Type, Print 21601 610 State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 04959 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ranny Preston Townsend Sr. Day Year 2010 A M Medical 03-6:30 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Coastal Hospice at the Lake Salisbury Wicomico 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign 8. Date of Birth 218-20-9658 1**X** M 2 □ F 79 Months Days Hours **Director** 1011811930 Maryland Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Somerset Princess Anne 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 30483 Linden Ave. Townsend 21853 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 X Yes 2 No
If Yes, Give Army
Year or Dates. Black, White, etc. Page 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Preston caretaker property Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Russell Townsend Nancy Kathryn Elliott 19a. Informant's Name/Relationship (Type, Print)
Robert R. Townsend brother 19b. Mailing Address Street and Number or Rural Route Number City or Town, State Zip Code 32136 Mt. Hermon Rd., Salisbury, MD 21804 Kuup. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 2 4 10 Salisbury, MD Signature of Funeral Service Licensee 22 Name and Address First Home Professional Association Jampson 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Firysician/ Onset and Death MALIGNANT LUNG disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abusing and attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 No been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Yes 27 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) HOSPICE filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury Accident Suicide 1 ☐ Yes 2 ☐ No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and the of certifier 29d. Date signed (Month, Day, Year) 5 mt 00058410 IVA 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

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egistrar's Signature

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Amend Item 9 per FH G900 2/22/10 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11, February 2010 8:55 \mathbf{A}^{M} John M. Urban /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Frederick
Index 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1023 Homewood At Crumland Farms Frederick Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months Washington Director 86 May 6, 1923 555-28-0234 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is invalical Examiner must be notified at any injury or other traumatic event, it is invalical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Funeral Director Frederick Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21701 7407 Willow Road Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 🙀 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Senior Intelligence Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Robert E. Urban Anastasia Baranova 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marvel Jane Hoke Urban / Wife 7407 Willow Road, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) February 13, 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg, Maryland Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2010 22. Name and Address of Facility
Keency and Basford PA Funeral Home
MO1473 106 E. Church Street, Frederick, Maryland 21701 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Stage rankinsons **Physician** nd disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner seven ha Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). fo the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): inding physician use as the burial Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atter for u 3 🗆 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No the o 9 Unknown signed by to σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To this After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. ours after death.
neral Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 🖳 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DECUIT -12-2010 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Obosen DV Frederick MD 21702 Hernen 50 Shah Thomas 31. Date filed (Month, Day, Year)

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State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DANIEL GORDON WARD 2010 21:30P FEB Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SHADY GROVE ADVENTIST MONTGOMERY HOSPITAL ROCKVILLE Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 ☑ M 2 ☐ F Months Davs Hours (Month, Day, Year) FEB 12 1 Director 212-64-6973 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MONTGOMERY ROCKVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 502 BURGUNDY DRIVE 20850 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 2 1 No ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: WHITE 3 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) SALES RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HERBERT G. WARD BETTY M. GATES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DALE STEWART / BROTHER-IN-LAW ASTER CT., MARTINSBURG, WV 25404 ant: If item ? 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or PARKLÁWN ČEMETERY 2/18/2010 ROCKVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral S rvice Licensee Name and Address of Facility
HILTON FUNERAL HOME
P.O. BOX 86, BARNES 20838 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ ACUTE ANTERIOR MYOCARDIAL INFARCTION Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for an a consequence of, or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Yes 2 No 1 Yes 2 L 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à CARDIOGENIC SHOCK 2 No Completed 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 은 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 🗌 the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2085

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O Physician/ 30M Dale Whitten 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Salis Jicomico 101220C at HOSDICE 5. Social Security Number If Unde Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min. (Month, Pay Year De Taware 8-54 Director 212-66-0893 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No Salisbury Wicomico MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21801 214 Maple Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married 1973 1 ☐ Yes 2 X No Specify: Specify 3 Divorced White 1977 Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Welding Welder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Willey Whitten Patricia Jean Robert Oliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1266, Salisbury, Maryland 21802 <u>Linda L. Whitten - Wife</u> 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Department of Important; If it any Injury or o cemetery, crematory or other place, 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Crematory of Delmarva 1-29-2010 4 Donation 5 Other (Specify) Delmar, Delaware Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complica ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one Onset and Death Immediate Cause (Final LIVBU Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) as the burial-transit The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Por Month Year 9 Unknown should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital: 2-1 No 1 Tes HOSPICA ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)

Baltimore, Maryland 21215-0036 P.O. Box 68760 Records, this certificate has Division of Vital Hospital or Attending Physician: funeral director, Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After leted filled in by the funer (Month, Day, Year) Natural 2 Accident work? injury 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be within 24 hours after de To the Funeral Director 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gratifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier ANA 20058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2180 BOX 1733 6 Huntin egistrar's Signatur Day, Year) FEB 0 1 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23e per doc 9900 2-25-10 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Carolyn Ruth Welch January /Medical 27, 2010 2:17 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF 68 Director 10 20 1941 215-36-0035 Usual Residence of Decedent Maryland with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Parsonsburg Wicomico 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ŏ 6237 Whitman Road 21849 Funeral USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or iteme 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Completed by Specify 3 ☐ Widowed 4 ☐ Divorced white natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 school cafeteria manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental I ant: If Item 27 ie marked of Elmer William Blackson ပ Florence Elizabeth Holloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond N. Welch husband 6237 Whitman Rd., Parsonsburg, MD 21849 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of himportant: if its any injury or ot one. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Grove Cemetery 2 1 10 Parsonsburg, MD 21. Signature of Funeral Service Livensee Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Ket 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death therosclerot Immediate Cause (Final Pnysician pronar disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physiclen Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year Day 5 Other (specify) signed by the at Id be detached for 1 ☐ Yes 2 No 9 ☐ Unknown 4☐ Pregnant at time of death 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be nen Completed 1 Yes 2 No 3 Probably 4 Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? 2 3 No tal or Attending Physician: Tr s after death. si Director: Atter this certificate ed in by the funeral director, pa 1 Yes 1 🗆 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other. 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 2 ReVOutpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) ٩ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name address of person who completed cause of death (Item 23a) (Type, Print) (10WQ 100 32/Registrar's Signature

State Registrar

31. Date filed (Month Pa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04964 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 08561 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** City, Town, or Location of Death 4c. County of Death op Mar 6-2101 Munore N/A If Under 6. Sex . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Funeral 1 🗆 M 2 🐼 F Months Days Hours Min. Month, Day 92 76 Director Washington, DC Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5400 Vantage Point Road Apt. 1208 21044 USA "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : 2 💢 No Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: 3 X Widowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) t of Health and Mental Hygiene.
If item 27 is marked other than or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Grose Fannie Cessna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Louise Armiger/Daughter 4 Michael Way Pennington, NJ 08534 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 21 1 Burial 2 X Cremation 3 Removal from State ō permit. Page Department of Important: If any injury or Atlantic Crematory 4 Donation 5 Other (Specify) 2010 Glen Burnie, MD . Signature of Funeral ac 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Road Timonium, MD 21093 0 Flagle Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final shock Onset and Death Physician/ Medical resulting in death) Due to (or as a onsequence of Examiner neumonia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 ¥ 9 ☐ Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Disease Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe Yes 2 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Dther: 1 Depatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No Accident Investigation Suicide 6 Could not be 28e Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after To the Funeral Direct Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier

State Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)

FEB 23

Registrar's Sign

120 Name and address of person who completed cause of death (Item 23a) (Type, Print)
1 Com 1. Stevens, MD 225 Greene St, Bathmare, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Maryland / De State of Maryland / De Registrar	partment of Heal 02/23/2010di ertificate of Dea	Ith and Mental Hyg hb ith	giene 2010	04965
			Decedent's Name (First, Middle, Last)		2. Date of Dea	th	3. Time of Death
	Physicia Medic	n/	WILL, AM — BLANW 4a. Facility Name (If not institution, give street and number)		JANUAN	9 27 2010	12:30 PM
- Charles	Examin			4b. City, Town, or Local		4c. County of Death	1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	April May) If Under 1 Year If U	Inder 24 Hrs. 8. Date of Birth	9. Birtl	hplace (State or Foreign
Н	Director		219–38–3454 XX ^{M 2 □ F} 67 Yrs	Months Davs Hou	ours Min. June 25	^{Year)} 1942 Col	Unk
	D WO		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d, Inside City Limits
	ryland I-f sh ied a	Director	10a. State 10b. County 10c. City, Town or MD Baltimore Dundal				1 Yes 2X No
	r 28a notif	Dire	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	
	with the 23a o	Funeral	7232 German Hill Road	21222		United S	
980	a filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates.	3. Was Decedent of Hispanion If Yes, specify Cuban, Me: 1 ☐ Yes 2 X No Specify Cuban Specific No Spec	ic Origin? (Specify Yes or No- exican, Puerto Rican, etc.) eccify:	14. Race - Amer Black, White Specify: Wh:	, etc.
Baltimore, Maryland 21215-0036	72 hour	Completed	(Specify only highest grade completed) (Gi	ecedent's Usual Occupation ive kind of work done during a. DO NOT use retired)		16b. Kind of Business I	ndustry
212	within giene. ier thar , the N		Elementary/Seconday (0-12) College (1-4 or 5+)	Fireman		Fire Se	rvice
and	ntal Hy ed oth	To Be	17. Father's Name (First, Middle, Last) Unknown		Mother's Name (First, Middle, I Unknown	Maiden Surname)	
Ϊχ	age 1 and 2 should be file ont of Health and Mental i it: If item 27 is marked o y or other traumatic eve				Jumber or Rural Route Number	: City or Town, State, Zio	Code)
Na	12 shualth ar 27 is rtrau		1		enue, Towson, N	· · · · · · · · · · · · · · · ·	,
re,	1 and of Hear item		20a. Method of Disposition 20b. Place of Di	sposition (Name of crematory or other place)	Date	20c. Location - City or	Town, State
imo	Page nent d ant: И			Carmel Cem.	02/04/2010		
Balt	permit. Page 1 a Department of I Important: If it, any injury or of once.		21. Signature of Funeral Service Licensee		Facility Skarda Fur Street, Balt:		
			23a. Part 1. Enter the disease or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, suc	ch as cardiac or respiratory arro	est,	Approximate Interval Between Onset and Death
	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	E FAILULE			Onset and Dodn
d	Examiner		DON'T CAM	Brady Ca	ardia		
. 6		Examiner	Sequentially list conditions, b. Green a non-aguar of Jir any, leading to immediate cause. Enter Underlying	of the second			
	ate be executed physician and the burial-transit	xan	Cause (Disease or ilnjury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
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760	cate by phys	edic	d				
Box 687	e death certificate be executed the attending physician and ned for use as the burial-transif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		23d. Date of del Month	ivery Day Year	
P.O.	hat the ed by detacl		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in	Part I. 23e. Did to	bacco use contribute to	the cause of death?
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Division of Vital Records,	Attending Physician: The law requires that the destrobation arricoath. ector After this certificate has been signed by the tay the funeral director, page 2 should be detached by the funeral director, page 2 should be detached.	Completed			24a. Was a autop perfor 1 🗆 Yes	prior to death?	topsy findings available completion of cause of 2 \square No
tal	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Othori	of Death (Check only one)		
ξ	Physi this c	은	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa		Nursing Home 5 Resid	ence 6 Other (Spec	ify)
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isio	I or Attendater deat Director:	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (S City or Tow	treet and Number or Rui	ral Route Number,
D	Hospital or 24 hours aft Funeral Dii eted filled in			ath occurred at the time, date			ited.
	To the Hospital or Attending Physician: Within 24 hours after death of the Funeral Director After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check conly one) 1 ☐ Certifying Physician: To the best of my knowledge, deal control of the basis of examination and/or in the basis of examination and the basi	vestigation, in my opinion, dea	eath occurred at the time, date a	nd place, and due to the	cause(s) and manner stated.
	To the I within 2 To the I comple		29b. Signature and title of certifier	29c. License num		29d. Date signed (Month	, Day, Year)
			full m.D.	RES-06	00	JANUARY FA	,2010
	₹		30. Name and address of person who completed cause of death (Item 23a) (Typer September 1940 FASTERN		TIMORE MID	21724	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	31	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-10-	
	Registr	ar	FEB 19 2010 Green B. A.	July 1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month EBRUAR MELVA BURLEY 4:54 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MARYCAND MEDICAL CTR BALTIMORE 8. Date of Birth If Under 1 Year If Under 24 Hrs.
Hours Min. 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗹 890 **Director** Carolin Usual Residence of Decedent or 28a-f show 10b. County 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 1 No Completed by 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Private Elementary/Seconday (0-12) College (1-4 or 5+) Nurse 17. Father's Name (First, Middle, Last permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or 27. 18. Mother's Name (First, Middle, Maiden Surname) Kando Kessle James 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Ruţal Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State DUNSVII 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sorvice Licensee 22. Name and Address of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death House Immediate Cause (Final Physician/ ANOXIC disease or condition Medical resulting in death) Examiner ERICARDIAL Sequentially list conditions, Examine ue to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events WEEKS sician and burial-transit DISSECTION requires that the death certificate be executed ASCENDING Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ should be 1 Yes 3 Probably 4 Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of 24a. Was an the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performed' 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify, ဂ 1 🗌 Yes 2 I XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) use of death (Item 23a) (Type, Print) BALTIMORE MD HEINFA 22 SOUTH GREENE ST State FEB 23 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death BROOKS FEBRUARY 15, 2010 Physician/ 12:40 AM DUGLA Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BOX SECOURS BALTI HOSPILAL MORE If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Days Hours Min. **Director** MD 220-64-9910 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Examiner must be notified at Completed by Funeral Director 1 XYes 2 □ No Baltimore MD na 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 21217 S A 23a 1933 W. Lexington Street 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 6 1 Never Married 2 Married 1 ☐ Yes 2 【XNo If Yes, Give Black Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled <u>10th grade</u> ulth and Mental Hygie 27 is marked other r traumatic event, tl Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ၉ Catherine Hurt Maxwell Paul Jeter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann Jeter-Sister Tabor Road Phila, Pa 19120 322 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Trinity Cemetery 2-22-2010 Balto, MD 4 Donation 5 Other (Specify) 21. Signature of uneral Service Licensee 22. Name and Address of Facility March East F/H Why Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events CIRRHOSIS Exami attending physician and for use as the burial-transit Due to (or as a consequence o resulting in death) Last Physician/Medical 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Box (in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death g 🗌 Unknown P.O. eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? Yes 2 No the Hospital or Attending Physician: Thin 24 hours after death. the Funeral Director: After this certifica 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 00030355 BON SECOURS HOSPITA Sand address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04968 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day P^{M} MILDRED BEEKS /5/2010 2:49 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1207 ADDISON ROAD SOUTH # 216 Capitol Heights Prince George's Social Security Number 6. Sex If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Hours Month, Day, 22/19 Months Days Director Yrs 578-38-4242 87 Ivro. Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Prince George's Capito1 Heights ò 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? "natural", or items 23a or Funeral 1207 Addison Road South # 216 20743 United States hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 XNo Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced **Black** er than "natura, the Medical E 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed within thealth and Mental Hygiens item 27 is marked other the other traumatic event, the 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Willie M. Johnson Henrietta M. Essex 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any Injury or other to <u>Carolyn June / Niece</u> 0702 Castleton Way Upper Marlboro, Maryland 20774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill 2/20/2010 Suitland, Marvland 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityPope Funeral Homes, P.A. M 00981 Charles 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of, or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No detached for Month Day Year the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? þ pe Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autops this certificate ☐ Yes 2 🔀 No 1 Yes 2 XNo director, Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) hours after death.

neral Director: After this filled in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1-Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, To the Hospital within 24 hours a To the Funeral E Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) eath (Item 23a) (Type, 31. Date filed (Mont) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0 Month Physician/ 2010 11:55A M Bessick Medical Anna 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Glen Burnie ctr. Baltimore Washington Med. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F Months Days Hours Month, Day, Year) 18 Director 91 215-24-6888 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d Inside City Limits Director 1 Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or edical Examiner must be Funeral with 1 306 McDonald Road 21060 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status þ 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry than Elementary/Seconday (0-12) College (1-4 or 5+) 4th Grade Domestic and Mental Hygie is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ပင Charles Fields Nettie Bessick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 308 McDonald Rd, Glen Burnie, MD 21060 Norris McDonald Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Halls Church Cem. 02/20/10 Glen Burnie, MD Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21. Signature of Funeral Service Licenses 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of); ^{*}Examiner Due to (or as a consequence of): DISSUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown in the past 12 months? Month Year Dav signed by the a 1 ☐ Yes 2 🕽 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 2 😾 No 1 Yes 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) <u>0</u> 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural To the Hospital or Attending 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 063726 My marcosunmi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 now 31. Date filed (Month, Day, Year) State Registrar

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Physicia /Medio		John Kenneth Bacigalupa				F	ebnia	14 1	4 2010	1530M	
Examin	er	4a. Facility Name (If not institution, give street and number) SH AGNES HOSPITAL		4b. City, Town	mo	re			N/A		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	t birthday) Yrs.	If Under 1 Year Months Day		Min. N	Date of Bir Month, Da lar I	th Year 19	9. Birthp 9. Birthp Mar	place (State or Foreign tryland	
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th the or 28s	Director	10e. Street and Number		10f. Zip Code	е			10g. Citiz	en of What Cour	ntry?	
ath wi	ral	311 South Central Avenue			21202				ed Stat	es	
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within 72 ho iene. than "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	lent's Usual Occ kind of work dor DO NOT use reti isabled	ne durina ma	est of working		16b. Kin	16b. Kind of Business/Industry ${\rm N/A}$		
if Hyg other	BeC	17. Father's Name (First, Middle, Last)		IDADICA	18. Moth	ner's Name (F	First, Middle,	, Maiden S			
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y INIGIT y and 2 shou salth and 1 27 Is ma er trauma		19a. Informant's Name/Relationship (Type. Print) Louis Bacigalupa - Nephew		g Address <i>(Stre</i> Fenor					Town, State, Zip L 2 2 7	Code)	
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permit Depar Impor any in	(2 Junit of Funeral Service Densee	1						al Home, vne, MD		
Physician /Medical Examiner the prival-transit	l Examiner	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if a y, leading to minimal cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence) Due to (or as a consequence)	Since of): ` ONLA	node of c	lying, such a	is cardiac or r	espiratory a	rrest,		Approximate interval Between Onset and Death Of Wys	
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director,	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, offic	е	28f	Location (S City or Tov		Number or Rura	al Route Number,	
he Hospil n 24 hour he Funera pletely filli	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle and manner stated.	edge, death n and/or inv	occurred at the estigation, in m	e time, date a y opinion, de	and place, an	d due to the at the time,	cause(s) date and	and manner as s place, and due to	stated. the cause(s)	
To the within To the Complex C	ğ	29b. Signature and title of certifier MD		P	anse number 240	58		29d. Date	signed (Month,	Day, Year) 2010	
		30. Name and address of person who completed cause of death (Item 2:		Frint) FGNE	< H	DSPITA	N 1	301	TIMAD	= MA	
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signatur	<i>ر ر</i> د.	10/100) //	13/11/	10/1-	, ul	1111010	71110	
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State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day S **Physician** Month 20 lb THEA -30 PM /Medical 4a. Facility Name (If not institution, give, street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** OSPI Balti more 1 4 8. Date of Birth (Month, Day, Year) 2-3-1958 Year I If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 72-8252 1**X** M 2□ F Months Days Hours Min. ΜD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be notified at once. Φ M **Funeral Director** 1 Des 2 □ No Himore 10e. Street and Numbe 10g. Citizen of What Country? ચાઢા 6 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Completed by Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation Kinth of Busine 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ongary (0-12) College (1-4or 5+) rogram Mother's Name (First, Middle, Maiden Surnam Be ပ Royte Number, City or Town, State, Zip Code, 19b. Mailing Address (Street and te Ave, Batto., MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 4 Donation 5 Other 3 Removal from State Brooklyn 2-25-10 5 Other (Specify) 21. Signature of Funera Service Ligensee Funeral Services Pilce 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 21 No within 24 hours are. ...

To the Funeral Director: After this verse for the funeral director. Certification: To 1 Tes Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 21202 OSEPH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 23 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Dav **Physician** Τ. Brice Julian М Feb. 2010 10PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arundel 7534 Baltimore Annapolis Blvd Glen Burnie Anne 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours 1 ☑ M 2 🗆 F Davs 214-14-7210 91 **Director** 24,1918 Georgia Dec. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Exercines must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 7534 Baltimore Annapolis Blvd. 21060 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian Black, White, etc. 1 DaYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☐ No Specify \$ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Civil Service Social Security 7 is marked other traumatic event, II permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) ဂ Julian T Brice Gladys Steagall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3453 Brookhaven Road Pasadena MD 21122 Barbara B Hartford daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 2/22/10 Baltimore Maryland 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD 21122 23a. Pat 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ath mmediate Cause (Final Physician disease or condition resulting in death) 0000 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Por Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No the detached 9 I Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 ☐Yes 3 No 1 ☐Yes 2 No Hospital or Attending Physician: eral Director: After this certification by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 X Residence 6 □ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1XX Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital c within 24 hours af To the Funeral D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

FEB 23 2010

31- Date filed (Month, Day, Year)

32. Registrar's Signature

no

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thaddeus Bell, Jr. 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ceeil Poir A MARYLAND ocial Security Number HEALTH CARE SYSTEM DERRY 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F (Month, Day, Year) Hours Country) Maryland 65 **Director** 212-42-4336 1944 June Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🛛 No Marland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 306 Highland Drive Apt. 101 21061 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married XYes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: If Yes, Give White 3 Widowed 4 Divorced Completed Year or Dates. 1965-67 permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical.] 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Glass Company Pallitizer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Thaddeus Bell, Sr. Marietta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD²1061 Linda S. Bell - Spouse 306 Highland Drive. 101 Apt 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery Feb. 25,2010 Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, PA 3111 Mountain Rd., Pasadena, MD 21122 23a. Par 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart follure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementin disease or condition resulting in death) NKNOW Medical Due to (or as a consequence of): **Examiner** rok Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury Pertension Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Mellitus RtRS Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 N within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

H+

AME

Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signatu

D24648

Up Mary 1 And Health Care System, Prery Point, MD 21903

			Pleas	se Type or Print					_			
			For State Registrar	State of Mary		artment of F <i>rtificate of l</i>			iene _{eg. No} 2010	04971		
			Decedent's Name (First, Middle, L.)	ast)		·	Joann	Date of Deat	h	3. Time of Death		
	Physici /Medic		Baby Girl Brown					FEBRUARY	Day Year	12:33 PM		
	Examin		4a. Facility Name (If not institution, gi	,			r Location of Death	1	4c. County of Death Baltimore			
	uneral		The Johns Hopkins I 5. Social Security Number 6.		yrs. last birthday)	Baltimore If Under 1 Year	If Under 24 Hrs.		te of Birth 9. Birthplace (State or Foreign			
	irector		infant	1 □ M 2 🖾 F	Yrs.	Months Days	Hours Min. 27	Feb 11,	, 2010 Maryland			
land	ow		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limits		
Mary	a-f sh fied a	ctor	MD Baltin	ore	Randall	stown				1 ☐ Yes 2X No		
vith the	or 28 De not	Director	10e. Street and Number			10f. Zip-Code		10	og. Citizen of What C	ountry?		
eath v	ns 23a must k	Funeral	4322 Star Cir.	12. Was Decedent Ever	in U.S. 13.	21133 Was Decedent of H	lispanic Origin? (Si	necify Yes or No-	USA 14. Race - Am	erican Indian		
affer d	or iter		1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2X No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi			
1 5-0036 172 hours aft	ural",	d by	3 Widowed 4 Divorced	Year or Dates:					орослу.			
in 72	n "nat fedica	Completed	15. Decedent's l (Specify only highest g Elementary/Secondary (0-12)	rade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	rking	16b. Kind of Busines:	s/industry		
Z1Z1 od within	er than	Com	Infant	College (1-4 or 5+) Infant		Infant			Infant			
Viana ould be fife Mental HV	d oth	Be	17. Father's Name (First, Middle, Las.	unk			18. Mother's Nar Davina	me (First, Middle, I	Maiden Surname)			
should	us wenear "ygene" is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	၉	19a. Informant's Name/Relationship	(Type. Print)	19b. Maili	ng Address (Street			; City or Town, State,	Zip Code)		
Maind 2 sh	27 is er trau		Davina Brown/mo	ther					laryland 2			
ore, les 1 a	Important: If item 27 is marked any injury or other traumatic ev		20a. Method of Disposition 1 Burial 2 Cremation 3		20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	ce)	Date :	20c. Location - City o	r Town, State		
baltimore bermit. Pages 1.	rtant; njury		4 Donation 5 Other (Spec		4 2	2 Name and Addre	I I					
perm Dens	any i		21. Signature of Funeral Service Lice Ronald S						. Baltimor	e Street		
	1		23a. Part 1. Inter the diseas, o cor shock, r heart failure. List only	nplications that caused the one cause on each line.				or respiratory arre	est,	Approximate Interval Between		
	sician		Immediate Gause (Final disease or condition resulting in death)	_a EXTREM	ME PR	REMATI	URITY	l .		Onset and Death		
	edical ıminer		resulting in death)	Due to (or as a co		PREUM	metat	> A X				
*		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	unsequence of.							
executed	nd transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C		- DISTR	JESS S	YNDRO	ME			
be exc	been signed by the attending physician and should be detached for use as the burial-transit	8	resulting in death) Last	Due to (or as a co	insequence oi):							
oo/o	g phys as the	Physician/Medic		d		·_						
DOX	r use	ian/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p		☐ Ectopic pregnanc	у		23d. Date of de	elivery Day Year		
ne dea	the att	ysic	1 Yes 2 No 9 Unknown	4 Pregnant at time 9 Unknown	e of death 5 [Other (specify)			Wichtin	Day leal		
that t	e deta	by Pl	Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying cause gi	iven in Part I.	23e. Did tob	pacco use contribute	to the cause of death?		
cords,	en sigr							1 □ Ye	s 2 No 3 □ F	robably 4 🗌 Unknown		
a law r	nas be	Completed			·			24a. Was an autopsy perform	y prior to	utopsy findings available completion of cause of		
VICAL F	ficate h	o Co	25. Was case referred to medical	T-			26 Place of Door		2 □ No 1 □ Ye	s 2 🗆 No		
ysicla	s certii direct	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatier	nt 3 DOA Oth	or:		nce 6 🗆 Other (Spe	ecify) <		
ng Phys	fter thi		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	Worl	k?	28d. Describe ho	w injury occurred			
ttending	tor; A	icati	2 Accident investigation 3 Suicide 6 Could not	be 28e Place of injury	At home, farm, str		Yes 2 No	28f Location (St	reet and Number or F	Bural Boute Number		
al or A	Direct of in b	Certification:	4 Homicide determined	building, etc. (S)	pecify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,		Tana Transon,		
Hospita 24 hour	To the Funeral Director. After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burneral director.	edical (29a. Certifier 1 Certifying P (check only one)	hysician: To the best of my aminer: On the basis of exa and manner stated.	amination and/or in	h occurred at the tir evestigation, in my o	ne, date and place ppinion, death occu	, and due to the caurred at the time, d	ause(s) and manner a ate and place, and d	as stated. ue to the cause(s)		
To the	To the comple	Med	29b. Signature and title of certifier		•	29c. License		29	9d. Date signed (Mon	th, Day, Year)		
) Call	11/15		KES	5-000	F	EBRUARY	11 2010		
			30. Name and address of person who	and the second	n (Item 23a) (Type,	Print)	600	North Wol	fe St. Raltim	ore, MD, 21287		
	Sta		31. Date filed (Month, Day, Year)		Signature Jan	. A. B	000	.10:11: 1101	o, Daiuiii	0.0, 1110, 21207		
	Registr	ar	FEB 23 20	10 Centor	a. pa	Vices .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 3:00 P M February 2010 Frances Jane Bane /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Genesis La Plata Center La Plata Charles Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🖾 F Sept 22, 1927 Washington DC 82 577-32-2814 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exprint or must be rediffed at 1 ☐ Yes 2 ▼ No La Plata MD Charles Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number <u>USA</u> 20646 6900 Rose Lane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, it a Madical Examinat 1 ☐ Yes 2√∑ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: þ 3 ☐ Widowed 4 🖾 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) cleaning hospitality 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Ruth Pace James Elmer Buck ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6900 Rose Ln.; La Plata, MD 20646 Evelyn Bowie/friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Si natur ²² State Anatomy Board; 655 W. Baltimore St. Director Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease o ondition oronso **Physician** /Medical resulting in death) Due to (or as a consequence Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence Examine Hospital or Attending Physician: The law requires that the death certificate be executed ans marca tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths? 3 🗌 Ectopic pregnancy Day Year Month 5 ☐ Other (specify) ned by the a 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No certificate 1 ☐ Yes ours after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 00 1 🔲 Inpatient 1 ☐ Yes Certification: To 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide e Funeral certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

DHMH 17 Rev 1/2001

Registrar

30. Name and address of perso

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who completed cause of death (Item 23a) (Type

WALDORY, M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 04976

		1- For State Registrar		Certif	ficate of	Death			Reg. No.			
Physici	an/	1. Decedent's Name (First, Middle,	ecedent's Name (First, Middle,Last) enneth Louis Brockmeyer 2. Date of Death Month Day Year January 29, 2010 3. Time of Death 0830 hrs									
ledical Exami	ner	4a. Facility Name (if not institution,		·)	41	b. City, Town,	or Location o			inty of Death		
		106 N. Marilyn Avenue			е.	Essex				nore Cou		
Funeral Director		5. Social Security Number unk	5. Sex 7. A	ge (In yrs. last 53	birthday) Yrs.	If Under 1 Ye	ear If Under ays Hours		Birth (MM/DD/Y	Ti-	thplace (State or n untryMaryland	
any		Usual Residence of Decedent 10a. State 10b. County 1	unk	10c City To	own or Location	n 11nk					10d. Inside City Limits	
≱ .	Ļ	MD (Carried Mark)	unk	,		GIII					1 X Yes 2 No	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number Unk				10f. Zip Code	unk		10g. Citizen o USA	f What Cour	ntry?	
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after d	by F		rced If Yes, Give Year or Dates:			Yes 2 🔀 N				whi		
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36 hin 72 e. than "	ompleted	Elementary/Secondary (0-12)	College (1-4 or	5+)								
5-0C led wit Hygien other the M	ပ	17. Father's Name (First, Middle, L	_ast)					s Name (First, Middl	e, Maiden Surna	ame)		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be	Al Brockmeyer 19a. Informant's Name/Relationshi	(Torres Driest)		40h Mailina	Address (Ct-		h Downey	Lumban City or	Town Ctate	Zin Code)	
MD 2 nd 2 shoul alth and M m 27 is m	ပ	Rhonda Brockmey		- 4		,		St.; Orla			, Zip Code)	
Ore, Nges 1 and 2 to Frealth: If item 2		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from S			ion (Name of o		Date		ion - City or	Town, State	
Baltimore, permit. Pages 1 at Department of Her Important: If ite		Donation 5 K Other Spe 21. Signature of Fineral Service Linald S.	we byre					oard; 655			e Street	
Physician	\dashv	23a. Part I. Enter the disease, or co	omplications that cause	d the death. De	o not enter the	timore mode of dyin	Mary g, such as ca	1and 2120 ardiac or respiratory	1 arrest, shock, o	r heart	Approximate Interval	
Medical Examiner		failure. List only one cause of Immediate Cause (Final disease	on each line. a. Acute al								Between Onset and Death	
LXammer		or condition resulting in death)	Due to (or as a cons	sequence of):								
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3760, ificate be g physicals the burner of t	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	me of pregnar	ncy				23d. Dat	te of delivery	Day Year	
Box 687 ne death certific the attending p	Physician/M	past 12 months? 1 Yes 2 No 9 Unkn	4 Pregnant a	it time of death		er (Specify)	Ectopic	pregnancy	Miorit	ui L	ay 1 C ai	
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed death ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - trans	by	Part II. Other significant condition	ons contributing to dea	th but not resu	ulting in the ur	nderlying cause	given in Par				the cause of death? ably 4 Unknown	
Division of Vital Records, ral or Attending Physician: The law requir is after death al Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed				-				as an 24 topsy rformed?		topsy findings available ompletion of cause of	
tal Rection: The l	Con						- (5 " /	1 ✓ Ye		1 🗸 Ye	s 2 No	
Vital Rec ysician: The his certificate director, page	æ	25. Was case referred to medical examiner?	Hospital: 1 Inpat	ent 2 EF	R/Outpatient		Other	Check only one) Nursing Home 5	Residence	6 🗸 Other	: Scene	
of Viring Physical After this funeral dir): To	1 Yes 2 No 27. Manner of Death	28a. Date of In (Month, Day,	C	8b. Time of In	jury 28c. In	jury at Work	? 28d. Descril	oe how injury oc	curred		
ion trendir leath tor: A	atio	1 Natural 5 Pendir 2 XAccident Investi			d 8:20	am 1	Yes 2X	140	t expos onment	ea Lo		
ivis I or At a after d I Direc	Certification:	3 Suicide 6 Could	not be 28e. Place of I		e, farm, street	, factory, office	building, etc		n (Street and No n, State) arlyn Av		ral Route Number, City	
Division To the Hospital or Attendi within 24 hours after death To the Funeral Director: , completely filled in by the fi		29a. Certifier 1 Certifying Phy	ysician: To the best of r niner: On the basis of ex	ny knowledge,	death occum	ed at the time,	date and pla	ce, and due to the c	ause(s) and mar	nner as state	ed.	
To the within To the comp	Medical	29b. Signature and title of certifier	and manner stated				nse number				nth, Day, Year)	
		Margante 1	meskule				C.M.E.			30, 2010		
		30. Name and a ress of person was Margarita Korell MD.	who completed cause of Assistant Medica			nn Street	Baltimore	, MD 21201				
	tate	31 Date filed (Month, Day, Year)	Registr					,				
Regis	TOTAL STREET	FFR 23 2	Man Physia	1 4.	SALES CONTRACTOR	B-Art 11						

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James	Blangio

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oo Diangio		1- For State	e or waryland		rtificate o			Monta		eg. No.	. U I U	0421
Physicia ledical Exami	ın/	Registrar 1. Decedent's Name (First, Middle, L James Edward I		₹.					2. Date of Dea Month February	th	Year	3. Time of Death 0830 hrs
		4a. Facility Name (if not institution, Maryland General Hosp	•			4b. City, Baltir		ocation of De			unty of Death	l
Funeral Director		219-84-2513	Sex 7. Ago	e (In yrs. 18	ast birthday) Yrs	Month	ler 1 Year ns Days	If Under 24 Hours	Hrs. 8. Date of Bir Min. Feb.		Foreig	thplace (State or in untry) MD
Maryland 28a-f show any 1 at once.	tor	Usual Residence of Decedent 10a. State MD			Town or Local		Codo			Og Citizen	of What Cour	10d. Inside City Limits 1 X Yes 2 No
n the Mar 3a or 28a otified at	Director	10e. Street and Number 501 Paca Stree	et				201			USA	or will cour	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorce	12. Was Decedent Armed Forces? 1 Yes 22 ced If Yes, Give Year	Ever in U.	lf Y		fy Cuban,	Mexican, Pue	(Specify Yes or No erto Rican, etc.)	'	Race - Ameri White, etc. cify: Bla	can Indian, Black,
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-0036 1 within 7 1 giene. Ther than	Completed	1 2 17. Father's Name (First, Middle, La	ast)		Labo	orer	I1	8.Mother's Na	ıme (First, Middle, I		struc	tion
1215 Id be filed Mental Hy narked o event, th	To Be C	James E. Bland 19a Informant's Name/Relationship	go, Sr.		19b. Mailin	a Address			ia Fish		Town State	Zip Code)
MD 2 nd 2 shou alth and 2 m 27 is r		Fredonia White		20h I		Ber	yl A	ve. B	alto.,M	D 212		
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Balti permit. Departm Importa injury o		21. Signature of Funeral Service Lic		10					esley C ve. Bal		•	
Physician /Medical Examiner			each line. a. End Stage Rer	na Dis	ease	the mode	of dying,	such as cardia	c or respiratory arr	est, shock, d	or heart	Approximate Interval Between Onset and Death
. pol		or condition resulting in death) Sequentially list conditions,	Due to (or as a conse									
cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect.)									
al - a	ical	UNPENDED	dAMENDED		<u></u>							
Division of Vital Records, P.O. Box 68760, the Ilospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physici prietly filled in by the funeral director, page 2 should be deatched for use as the burn	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno	23c. If yes, outcon 1 Live birth 4 Pregnant at 9 Unknown		2 Fe	etal death ther (Spe	_	Ectopic pre	gnancy	23d. Da Mor	nte of delivery nth E	day Year
, P.O. Barries that the designed by the	by Ph	Part II. Other significant condition	ns contributing to death	but not re	esulting in the	underlying	g cause gi	ven in Part I.		obacco use		the cause of death?
of Vital Records, Ing Physician: The law requires Wher this certificate has been signineral director, page 2 should by	Completed								24a. Was autop perfo	rmed?		topsy findings available ompletion of cause of
tal Recians The	Be C	25. Was case referred to medical						of Death (Che	ck only one)			
of Viting Physici After this c	은	examiner? 1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie	ry	ER/Outpatient 28b. Time of		70/1	Other Nu y at Work?	rsing Home 5 28d Describe	Residence how injury o		· · · · · · · · · · · · · · · · · · ·
Division (all or Attendin s after death. all Director: A led in by the fu	ertification:	1 Natural 5 Pending 2 Accident Investig			ome farm etre	et facton		es 2 No	28f Location (Street and N	lumber or Pu	ral Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certifi	3 Suicide 6 Could r 4 Homicide determi	not be	July - At III	sme, raim, stre		, omoc bi	andrig, etc.	or Town, S		idiliber of Ita	
To the Hos within 24 h To the Fur completely	Medical		sician: To the best of my ner:On the basis of exar and manner stated									
F 3 F 3	ğ	29b Signature and title of certifier	. (V 00			29	c. License O.C.N				signed (Mor	oth, Day, Year)
	Ì	30. Name and a cress of person when Margarita Korell MD.	ho completed cause of d Assistant Medical			Penn St	reet. Ba	altimore, M	D 21201			
	ate		32. gistra		ıre						· . · · · ·	
Regist	исш	FEDZXX	1411 // /	4	II As a	A SE						

DHMH 17 Rev 1/2001 OCME 2006

OCME

10-01326	
Rodney Barlow	

Trouney Danow		I - For State Registrar	Otate	Of Ivial yla	Certif	icate of D		ia monta.		eg. No.	
Physicia	n/	Decedent's Name	(First, Middle,Las	st)					Date of Dea Month	Day Year	3. Time of Death
Medical Examin		Rodne		ames	Barlow				February	13, 2010 4c. County of De	1720 hrs
3		4a. Facility Name (if 1137 N. Fult		e street and nur	mber)		City, Town, o Baltimore	r Location of D	eam	4c. County of De	adui
Funeral		5. Social Security Nu		ex	7. Age (In yrs. last	birthday)	If Under 1 Ye	ar If Under 24	4Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9.	
Director	1	231.74.6	5831 ¹⊠	M 2 F	57	Yrs.	Months Day	ys Hours	Min. Aug.	09,1952	reign Country) VA
'n	ļ	Usual Residence of			Inc. City To	wn or Location					10d. Inside City Limits
d d		MD	TOD. Godiny			imore					1 Yes 2 No
varyland 28a-f show	Director	10e. Street and Num	nber		Dare		0f. Zip Code		1	0g. Citizen of What C	country?
vith the Maryland s 23a or 28a-f shov	ă	3310 Br	endon A	Avenue			2121	3		U.S.A.	
h with	Funeral	11. Marital Status 1 Never Marrie		12. Was Dec	edent Ever in U.S. rces?				(Specify Yes or No lerto Rican, etc.)	14. Race - Ar White, etc	nerican Indian, Black, c.
er deat		3 Widowed		1 X Yes	2 No	1 N	es 2 N	o specify:		Specify: B	lack
urs aft itural'	ē ē	15. Decedent's Edi		or Dates:		Sa. Decedent's	Usual Occupa			16b. Kind of Busine	ss/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at porce.	Completed	Elementary/Secon	ndary (0-12)	College (1	-4 or 5+)			e. DO NOT use	e retired)	School	Ruc
5-0036 lled within 7 Hygiene. I other than	E .	12 17. Father's Name (I	First Middle Last	2		Drive	<u>r</u>	18.Mother's N	lame (First, Middle, I		Dus
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MD and 2 sho		Lori Ma		nploye:	r I 20h Blo	9729 ce of Disposition	Phila	delphi	<u>ia Rd. B</u>	altimore	, MD21237 or Town, State
Ore, es l ar of Her If ite		1 Burial 2		Removal from	om State cre	matory or other	place)				
Baltimore, permit. Pages 1 ar Department of He. Important: If ite	1	4 Donation 5 21. Signature of Fur	Other Specify		Che	sapeak 122. Nan	e Cre	m . (02.23.10 VEA/Step	Beltsvi	lle, MD ohrmann,PA
Ba perm Depa Impo	-	duita	Sue Ri	the M	101443	871	7 Gre	en Pas	stures D	r.Balto.	
Physician		23a. Part I. Enter the failure. List only	e disease, or comp y one cause on e		aused the death. D	o not enter the	mode of dying	, such as card	iac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
lv edital Examiner	İ	Immediate Cause (For condition resulting			one intox	cication	1				Death
		Sequentially list cor	h	Due to (or as a	consequence ory.						
	je	if any, leading to im- cause. Enter Under	mediate	Due to (or as a	consequence of):						
- =	Examiner	(Disease or injury ti events resulting in c		Due to (or as a	consequence of):						
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60, ate be e ohysician	Medical	IF FEMALE:			23a,27,28 outcome of pregnar		тE, <u>g</u> 9	01 3/16	6/10_TT	23d. Date of deli	very
6876 ertifica ding pt	sician//	23b. Was decedent p past 12 months		1 Live b	irth	2 Fetal	death 3	Ectopic pr	egnancy	Month	Day Year
Box 687 death certific	sici	1 Yes 2 N	lo 9 Unknow		ant at time of death own	¹ 5 Other	(Specify)				
O. Bat the dath the trached	/ Phy	Part II. Other signif	ficant conditions	contributing to	death but not resu	ulting in the und	erlying cause	given in Part I			e to the cause of death?
cords, P.O. law requires that the has been signed by 2 should be detach	od by				· · · · · · · · · · · · · · · · · · ·						Probably 4 Unknown
of Vital Records, ng Physician: The law requir Wher this certificate has been someral director, page 2 should be	Completed	_							24a. Was		e autopsy findings available to completion of cause of
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f Vital Rec Physician: The I er this certificate I	Be	25. Was case referr examiner?	_ 1	Hospital:	npatient 2 El	R/Outpatient 3		ce of Death (Ch Other	ursing Home 5	Residence 6 ✓ 0	ther Scene
n of Viding Phys	۱.	1 Yes 27. Manner of Death	2 No I	28a, Date		8b. Time of Inju		ury at Work?		how injury occurred	
Sion of trending death.	tion	1 Natural 2 Accident	5 Pending	E4 2	/12/2010	Fd 5:10	pm 1	Yes 2 X No	unk		
Division fal or Attendi rs after death.	Certification:	3 Suicide	6 X Could not determine	be 28e. Plac	e of Injury - At hom	e, farm, street, house	factory, office	building, etc	28f. Location (or Town,	Street and Number of State) 1137 N	Rural Route Number, City Fulton Ave
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fi		4 Homicide 29a. Certifier (Check only)		(0)	t of my knowledge		d at the time	date and place		ore, MD se(s) and manner as	stated.
The H	Medical	(Check only one) 2			of examination and					and place, and due t	
7 5 8 6 8	Me	29b. Signature and	title of certifier	1				se number	· · · · · ·	29d Date signed	
		Maujoni	= The	Kull			0.0	.M.E.		February 14, 2	2010
110		30. Name and addre			se of death (Item 23 dical Examine)		n Street. I	Baltimore.	MD 21201		
V	ate	31. Date filed (Mont	h, Day, Year)	-	egistrar's Signature	^ -					
Regist			23 2010	Cheena	J. B. A						195

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ilse Maria Buitron Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner riursing Harford HONRE detrace 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7, Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Months Days Hours Min (Month, Day, Year, Country) Yrs. Director 212-38-1726 Germany Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d, Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Harford Edgewood 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1307-D Clover Valley Way 21040 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes, 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced White permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Aherla Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Adelqunde (nmn) Peters Hans (nmn) Lammerich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1307-D Clover Valley Way, Edgewood, Maryland 21040 Rodolfo Buitron / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Baker's Cemetery Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2-24-10 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final (a) whin) Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Exam the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 month Pregnant at time of death be detached Unknown 9 🗌 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Division of Vital Records, Completed peen Were autopsy findings available 24a. Was an autopsy performed? prior to completion of death? certificate has completed filled by the funeral director, page 2 1 Yes 25. Was case referred to edica or Attending Physician: Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 📑 No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours a er death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work?
1 Yes 2 No 5 Pending ☐ Accident Investigation M 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b, Signature and title of certifier 29c, License number 29d. Date signed (Month. Day, Year) 1010 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) MD whe

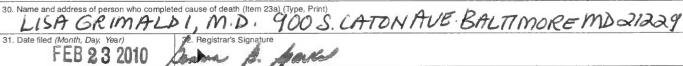
DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5:18 AM **Physician** MARIE BURNS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** AGNES Baltimore HOSP ITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | North | Days | Hours | Min. | 8/26/37 | Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2**XX**F 72 MaryTand Yrs. 219-32-8787 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 1 ☐ Yes 2/X No Director Baltimore Catonsville Maryland the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe death with 21228 USA 717 Maiden Choice Lane Funeral other traumatic event. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes XX No Specify: Specify: White Completed by Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Church Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Joseph Basel Sn Anna Alberta Guenther မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is in any injury or other traum once. 2757 Piedmont Hollow Drive Finksburg MD 21048 Michael T Burns Son 20a. Method of Disposition
1 ☐ Burial 2 AACremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Feb 24, 2010 GreenMount Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc gnature of Funeral Serv 6500 York Road Baltimore, Maryland 21212 Approximate
Interval Between
Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RESPIRATOR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner INKNOWN NEUMONIA Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): burial-t P.O. Box 68760. physician certificate be Completed by Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 mo Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) bed i 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 🗆 No of Vital 2 40 1 □ Yes 1 □Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this nours after death.

neral Director; After this
filled in by the funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number *P* **2** 405 9 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) FEB 23 2010



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February Michael Edward Clifton 2010 6:03 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2305 Falling Creek Road Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** . 1<u>969</u> 1 🕱 M 2 🗆 F Months Days Hours (Month, Day, Director Maryland 40 214-92-1996 Usual Residence of Decedent Show 10b. County 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 23a or 28a-f Maryland Montgomery Montgomery Village 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19746 Crested Iris Way 20866 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc "natural", or Completed by 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed where the freet of Health and Mental Hygiene. Tant If item 27 is marked other than "naturation". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) GIS Analyst U.S. Government 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James R. Clifton Eva Marie Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johanna Nathanson/ Friend 2824 Thicket Way Olney, Maryland 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Feb. Dat 23 Important: If it any injury or o Department of 1 Durial 2 X Cremation 3 Removal from State Metro Crematory 4 Donation 5 Other (Specify) 2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland, Inc. Serge George MacNabb 299 Frederick Road Baltimore, Maryland 21228 E Mark 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Brain Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Dav Year 2 🗌 No 9 Unknown Unknown ģ eral Director; After this certificate has been signed ifilled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director. After this certificate to completed filled in by the funeral director, page 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending Accident Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address d cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Reema Jalali, MD 7350 Van Dusen Road, #130 Laurel Maryland

			State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2	110 04982
		ļ	Decedent's Name (First, Middle, Last) 2. Date of Death	3. Time of Death
Ш	Physici /Medic		kathryne Belva Corbin Feb 20 20	
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Coun	ty of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. The security Number of the security Number o	9. Birthplace (State or Foreign Country) MD
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Maryl. I-f sho fied at	tor	10a. State 10b. County Carroll 10c. City, Town or Location Westminster	1 □Yes 2 ⊠ No
	th with the 23a or 28c ist be noti	al Director	10e, Street and Number 3457 Uniontown Rd 10f. Zip Code USA	f What Country?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show either traumatic event, the Medical Examiner must be notified at	by Funeral		ace - American Indian, ack, White, etc. White
15-0	"natu	letec	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	Business/Industry
2121	within jene.	Completed by	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Hou	sewife
Maryland 21215-0036	should be filed and Mental Hygis s marked other umatic event, the	To Be C	17. Father's Name (<i>First, Middle, Last</i>) 18. Mother's Name (<i>First, Middle, Last</i>) Martha Rehecca Cro	-
	: 1 and 2 shou Health and M tem 27 is mar ther traumat	-	19a. Informant's Name/Relationship (Type. Print) Carol Wildesen-Rep 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 3457 Uniontown Rd. Westminste	
Baltimore,	permit. Pages 1 an Department of Hea Important: If item any injury or other		1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **Commeter, Crematory or other place) Westminster Cem 2-24-10 Westminster Cem	n - City or Town, State
Balt	permit. Page Department o Important: If any injury or once.		21. Signature Funeral Service Ocense Common	
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	33
.O. Box 68	death certif e attending d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	Date of delivery Month Day Year
Δ.	quires that the de n signed by the a ald be detached to	by	Plate in Other Significant Continuous Continuous to death but not resulting in the discertific date of the Continuous Con	ontribute to the cause of death? 3 Probably 4 Unknown
or Vital Records,	The law requires that the rate has been signed by the page 2 should be detached	Completed	24a. Was an autopsy performed? 11 Yes 247 No	b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
ital		Be C	26. Place of Death (Check only one)	
	Phys r this ral dir	ြို	1 Yes 2 No Prospiration 1 Inpatient 2 ER/Outpatient 3 DOA Outlet 4 Nursing Home 5 Residence 6 DO	
Division	death ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Nur City or Town, State)	mber or Rural Route Number,
_	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical C		
	To th withir To th comp	Me		ned (Month, Day, Year)
	C-		2 111	- ^ 2 Z ~ 10
	5		30. Name and address of person who completed case of death (Item 23a) (Type, Print) Assor A. Tate w. o The Frederick A. Three	7877 cm, mo
	Sta Regist	ate rar	B	

10-01328	
Elwood Collins	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

LIWOOG COMMIS		- For State Registrar		tificate of De		vicitai riyg			U	04700
Physiciar	1/	Decedent's Name (First, Middle,Last)			_	- -	Date of Death Month	Day Year		3. Time of Death 1826 hrs
Medical Examin					ns Jr.		February 13	3, 2010 4c. County o	f Death	1020 1115
	ı	4a. Facility Name (if not institution, give street and number) Maryland General Hosptial			ıltimore	Sation of Death		40. Godiny o	Death	
Funeral	╗	5. Social Security Number 6. Sex 7. Age	(In yrs. la				8. Date of Birth	(MM/DD/YYYY)	9. Birtl Foreigr	
Director		213-62-3852 1XM 2_F	51	Yrs.	onths Days	Hours Min.	11 16	5 58	Cou	ntry) SC
any	-	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location						10d. Inside City Limits
≥	_	MD NA	E	Baltimor	·e					1 X Yes 2 No
Maryland 28a-f show d at once.	Ulrector	10e. Street and Number		10f	Zip Code		100	g. Citizen of Wha	at Coun	try?
h the N 3a or	[5	453 Manse Ct.			212			U.S.		
Imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It litem 27 is marked other than "natural", or items 23a or 28a-f shout other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?				nic Origin? (Speci exican, Puerto Ric		14. Race - White		an Indian, Black,
fter de		Widowed 4 Divorced If Yes, Give Year	No	1 Yes	2X No s	pecify:		Specify:	Вlа	ack
ours al atural		15. Decedent's Education (Specify only highest grade com	pleted)	16a. Decedent's Us	sual Occupation	(Give kind of work		16b. Kind of Bus	iness/Ir	dustry
n 72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5	+)	Correct				Dent o	of (Correction
21215-0036 Juld be filed within 7 Mental Hygiene marked other than tic event, the Medica	<u></u>	17. Father's Name (First, Middle, Last)				Mother's Name (Fi			, ,	
21215-003 uld be filed withi Mental Hygiene, marked other ti	a Re	Elwood Collins Sr.			F	uth Ha	nkins			
) 21; nould be mid Meris marrise ever	≗ૉ	19a. Informant's Name/Relationship (Type, Print)		1		nd Number or Rura				
MD and 2 sho alth and 2 sm 27 is		Antoinette Collins-Wife		453 Ma		Bali		20c. Location		
Ore, ges la lor Her transfer t		1 X Burial 2 Cremation 3 Removal from Sta	te cr	ematory or other pl	ace)					
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If item 27 is in injury or other traumatic.	ŀ	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	Gar	22. Name	and Address of	Facility				lls, Md
Balt permit. Departu Import		Glum Bokeke				West sh Ave,				21215
Physician	1	23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death.	Do not enter the mo	de of dying, suc	ch as cardiac or re	espiratory arres	st, shock, or hea	rt	Approximate Interval Between Onset and
/Medical /Examiner	١	Immediate Cause (Final disease or condition resulting in death) a. Atherosc. Due to (or as a conse			vascula	r Diseas	e			Death
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J	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a conse	quence of)	:					_	
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit		d. x UNPENDED AMENDED 23a	27 т	er me oq	01 3-25	-10 vt		_	_	
50, te be es ysiciar burial	Medical	IF FEMALE: 23c. If yes, outcome			01 5 25			23d. Date of o	delivery	
5876 rrtifica ling ph		3b. Was decedent pregnant in the past 12 months?		2 Fetal de	ath 3	Ectopic pregnancy	y	Month	D	ay Year
OX (Physician	1 Yes 2 No 9 Unknown	time of dea	th 5 Other (Specify)			6		
s, P.O. Bouries that the designed by the		Part II. Other significant conditions contributing to death	but not res	sulting in the under	ying cause give	n in Part I.	23e. Did tob	acco use contrib	oute to t	he cause of death?
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Reco	E						perform		eath? Yes	2 No
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of Vi	의	1 Yes 2 No Inpatie 27. Manner of Death 28a. Date of Inju		ER/Outpatient 3 28b. Time of Injury	DOA 28c. Injury a			Residence 6	Other:	
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Visic or Atte frer der Sirecto in by ti	<u>≡</u>	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Inj	ury - At ho	me, farm, street, fac	tory, office build	ding, etc. 28	Bf. Location (St or Town, Sta		r or Rur	al Route Number, City
Djy spital o neral L filled	Certification:	4 Homicide determined (Specify)				V (2	or rown, ora			
	Medical	29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of examiner:								
To with	ğ-	and manner stated. 29b. Signature and title of certifier	·		29c. License ni	umber		29d Date signe	d (Mon	th, Day, Year)
		my hu, ms			O.C.M.	E.		February 14	, 201	0
V	İ	30. Name and address of person who completed cause of d			altimore MC	21201				
Sta	te	Ling Li, MD Assistant Medical Examiner 31 Date filed (Month, Day Year) 32. Registrar	' ⊊ Signatur	Penn Street, B	aidifiore, ML					
Registr	ar	31 Date filed (Month, Day Year) 32. Registral	1. 4	arke						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month February 2010 4:46 P M Margaret Eileen Caudle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Funeral 1 □ M 2**X**XF (Month, Day, Maryland **1**932 **Director** June 219-28-9299 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Mariana. 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2XX No Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 1610 Pleasantville Dr. 21061 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Kehs Margaret Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond C. Caudle / Husband 1610 Pleasantville Dr. Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 2010 Glen Haven Mem. Park Glen Burnie, Maryland 21. Signature of Funeral Service 22 Name and Address of Facility.

Kirkley-Ruddick Funeral Home, P.A. n013 Crain Hwy. SE; Glen Burnie, MD 21061 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury Examiner burial-transi that initiated events resulting in death) Last Due to (or as a consequence of). attending physician for use as the buria Physician/Medical the Hospital or Attending Physicia The law equires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🛛 No Other: 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical I Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Cartifying Nurse Practioner: To the best of my knowledge

Division of Vital Records, P.O. Box 68760

State Registrar 29b. Signature and title of certifier

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Com egistrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Anna Irene Councill Fubruar 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death County of Death P 7. Age (In yrs. last birthday) 8. Date of Birth If Under 24 Hrs Birthplace (State or Foreign Country) MD ecurity Number **Funeral** 1 □ M 2 🗓 F Months Hours Min. 03 Manth Day 18 91 216-16-9271 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2 🗓 No Delta PA York County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 17314 USA 159 Riverview Rd death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race ~ American Indian, Examiner Black, White, etc ō þ 1 Never Married 2 Married Maryland 21215-0036 Yes 2 TNo within 72 hours after Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working ital Hygiene. ed other than " event, the Mer life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H
27 is marked of
traumatic even t. Page 1 and 2 should be fill thent of Health and Mental rtant: If item 27 is marked of jury or other traumatic ew မ George Wahl Irene Downs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 159 Riverview Rd Delta PA 17314 Mary D. Koermer (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 02-22-2010 Baltimore, MD Oaklawn Cemetery 4 Donation 5 Other (Specify) 21. Signature of Fundal Service 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Vementia disease or condition Medical resulting in death) Duato (or as a consequence of) WHISIM Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury to or as a consequence of MYNIHALIVA that the death certificate be executed attending physician and for use as the bunal-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? 1 Live Birth 4 Pregnant 9 Unknown Pregnant at time of death 9 Unknown Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires in 24 hours after death.
Funeral Director: After this certificate has been sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy prior to completion of death? completed filled in by the funeral director, page 2 💟 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other 1 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date sidned (Month. Day, Year) 19/10 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Division of Vital Records, P.O. Box 68760, 1

			For State Registrar	tate of waryit		rtificate of		vicinari	Reg. No. 2	010	04986
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Do Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give stre	ot and number)		Ab City Town o	r Location of Death	2	4c Cour	2016	10,00 710
and the same	Examin	er	7931 Elvaton Rd	st and number)		Glen Burn				Arundel	
	Funeral		5. Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year Months Days		8. Date of Bi			place (State or Foreign
	Director		216-34-1795 1□ M	2 XXF 72	Yrs.	Wollins Days	Hodis Will.	Apr 15,	1937		MD
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				1	Od. Inside City Limits
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	r 28a	Director	10e. Street and Number	, die	ar Burnie	10f. Zip Code			10g. Citizen o	of What Cour	ntry?
	th with	al D	7931 Elvaton Rd			21061			1	USA	
	r dea tems	Funeral	11. Maritai Otatao	Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or N Rican, etc.)	o- 14. R B	ace - Americ lack, White,	
36	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Evanifier must be notified at	by F		1 ∐Yes		1 □Yes 2X⊠ No	Specify:		Spec	o ^{ify:} Whit	e
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Ma	alth 27 I		Charles Carroll Husband				d, Glen Bur			.,, _ ,	,
re,	s 1 and 2 of Health item 27 I		20a. Method of Disposition	201		osition (Name of matory or other pla		Date	20c. Locatio	n - City or To	own, State
<u>m</u>	Page nent (ant: If ury ol		1 ☐ Burial 2 EX Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	Bayview, Cr			3, 2010	Baltimo	re, MD	
alt	permit. Pages 1 Department of f Important: If ite any Injury or of		21. Signature of Funeral Service Licensee		2	2. Name and Addre	ess of Facility ral Home, P	.A.			-
_	<u></u>		K. Gregory Fin	M01148		426 Crain	Hwy S., G1	en Burnie		61	Approximate
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О. В	he att	Physician/I	1 ☐ Yes 2 ☑ No	4 Pregnant at time		Other (specify)	-,			Month	Day Year
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of V	Physiclan: this certific ral director, i	To	1 Yes 2 No Hosp	1 ∐ Inpatient 2		INC 3 LI DUA			sidence 6 🗆 (ify)
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sic	I or Attending after death. Director: After d in by the funer	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - A	t home, farm, st		Yes 2 □No	28f. Location	(Street and Nu	mber or Rur	al Route Number,
Division	after after Direction by	Certification:	4 Homicide determined	building, etc. (Sp	ecify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			own, State)		
	To the Hospital or I within 24 hours after To the Funeral Direct completely filled in b		29a. Certifier 1 Certifying Physici (Check only 2 Medical Examiner								
1	the Ho nin 24 the Fu nplete	Medical	one)	and manner stated.	- Ination and/or ii			ined at the till			
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			OO Name and address of a second of	1	Itom ODs \ /T-		50108		2	122	20.0
			30. Name and address of person who comp				coo When	Burgai	am s	21061	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	1		48.81	*		
	Registr	ar	FEB 23 2010	answa	1 6.	and .					
DH	MH 17 Rev 1/2	001		100.00	1. 1	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Month Wayne Coffman Arnold 2010 February 12:25 AM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Jan 24, Year 936 1 🕅 M 2 🗆 F Months Days Hours 226-36-7127 74 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Rockville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4405 Bel Pre Road 20853 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 14 Yes 2 No Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: If Yes, Give 3 🗌 Widowed 4 🗆 Divorced Year or Dates. Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4+ Engineering Consultant Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Glenn A. Coffman Mary Ellen Ritenour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Coffman - Wife 4405 Bel Pre Road Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State unk Massanutten Cem. 4 ☐ Donation 5 ☐ Other (Specify) Woodstock, Virginia f Funeral Service Licensee Signature Dellinger Funeral Home 22. Name and Address of Facility 157 N. Main St. Woodstock, Virginia

of Hysicians Medical **Examiner**

Physician/

Medical

Director

Funeral

Completed by

Be

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MD

Examiner

Funeral

Director

show

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

(Check

30. Name and address of Nioke Wright, 31 Date filed (Month I

з 🗌 29b. Signature and title of pertifier

-	// 5-50 02/0	<u> </u>						U
(23a. Part 1 Enter the disease, or compliance, or heart failure. List only one	e cause on each line.		de of dying, such	as cardiac o	r respiratory arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	Lung Cano	cer					Onset and Death
	resulting in death)	Due to (or as a conseque	ence of):					
	Sequentially list conditions,							
2	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):					
0	Cause (Disease or illijury that initiated events							
Ĭ	resulting in death) Last	Due to (or as a conseque	ence of):					
2		4						
2								
	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnand					23d. Date of de	diver
2	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Fetal 4 Pregnant at time of de					Month	Day Year
3	9 Unknown	g 🗌 Unknown		. ,,				
	Part II. Other significant conditions con	tributing to death but not resul	ting in the underlying	cause given in Pa	art I.	23e. Did tobacco	use contribute to	the cause of death?
2						1 Ves	No 3 D	robably 4 🖾 Unknown
2						24a. Was an autopsy	prior to	topsy findings available completion of cause of
5						performed?	death?	s 2 🗆 No
3	25. Was case referred to medical examiner?			26. Place of D	eath (Check			
	1 ☐ Yes 2 🕱 No	ospital:	R/Outpatient 3 🗆 [OCA Other:	Nursing Hor	ne 5 Residence	6 Other (Spec	vifu)
5	27. Manner of Death	28a. Date of injury (Month, Day, Year)	8b. Time of Injury	28c. Injury at		8d. Describe how inju		
3	1 Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Worth, Day, Tear)	M	work? 1 ☐ Yes 2	□No			
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom	e, farm, street, facto	ry, office	2	28f. Location (Street a	nd Number or Ru	ral Route Number
	goommea	building, etc. (Specify)				City or Town, Stat	e)	
3	29a. Certifier 1 Certifying Physic	cian: To the best of my knowled	dge, death occured a	t the time, date ar	nd place, and	due to the cause(s) a	nd manner as sta	ated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

February 11, 2010

29c. License number

D69916

30V

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

State Registrar erson who completed cause of death (Item 23a) (Type, Print)
At. MD 1500 Forest Glen Dr. Silver Spring, MD

rar's Signature

			Plea	se Type or Pri					-		egible.		
		State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 2 0 1									nın	04988	
		1. Decedent's Name (First, Middle, Last) 2. Date of Death								010	3. Time of Death		
Physicia /Medic		Ila Weaver Coss February 3, 20									2010	12:30 A M	
Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death									4c. County of Death		
_		Asbury	sburg	8. Date of Birt	h		-						
Funeral Director		Months Days Hours Min. (Month, Day, Year)							Co	untry) `			
pu ,		Usual Residence of			140- 0:5:	Taura 1						10d Inside City Limits	
arylar shov	'n	10a. State	10b. County	0.000		Town or Lo							
the M 28a-f	Director	MD 10e. Street and Nur		gomery	Gail	thersb	10f. Zip Code			10g. Citizer	n of What Co	41	
3a or	al Di		ssell A	Avenue			2087	7		USA			
death	Funeral	11. Marital Status		12. Was Decedent		. 13. V		lispanic Origin? (S an, Mexican, Puert	pecify Yes or No-				
filed within 72 hours after death with the Maryland Hygiene. Yher than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be redified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No ☐ If Yes, Give					1 □Yes 2 No	Specify:	,				
hour:	ed b	3 X widowed	15. Decedent	Year or Dates:		16a. Deced	dent's Usual Occup	pation		16b. Kind	of Business/I	ndustry	
in 72 3. In "na	plet	(Spec	cify only highes	st grade completed) College (1-4or	5.4)	(Give.		during most of wor	king			•	
d with giene er the	Completed	12	Tidary (0 12)			Hom	emaker						
be filk	Be	17. Father's Name		_{Last)} :e Weaver				18. Mother's Nam					
hould d Mer marke matic	으	19a. Informant's Na				10h Mailin	on Address (Street					Zin Code)	
nd 2 s Ilth an 27 is i				n - Daughter									
s 1 ar of Hea item		20a. Method of Disp	position		20h Pis	ace of Disno	sition (Name of		Date				
Page ment ant: If ury o		142⊒ Burial 2 L 4 ☐ Donation		3 ☐ Removal from State pecify)			natory or other place orial		-10	Burk	eville	, VA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deprit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marylan Examinar must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Doyne-Burger-Davis Funeral Home 106 Venable St. Farmville, VA 23901											
<u>σ</u> □ = α οι		The same	be disease of	complications that cause	d the death	Do not onto					A 2390		
		shoot, or hea	ırt failure. List	only one cause on each	line.					1631,		Interval Between Onset and Death	
Physician /Medical		disease or condition resulting in death)	n	a. Chroni Due to (or as			ve Pulmor	nary Dise	ase		-		
Examiner		On a section line and		h	,	,							
pe sit	Examiner	Sequentially list conditions, Due to (or as a conse juence of): cause. Enter Underlying Cause (Disease or injury											
xecution and	xam	that initiated events resulting in death) Last C. Due to (or as a consequence of):											
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rtificat ng phy as the	Physician/Medical												
ath cer ttendir	an/N	IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fet							230	9. Birthplace (State or Foreign Country) Virginia 10d. Inside City Limits 1 Yes 2 No No No No No No No			
the a	/sici	In the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown 4 □ Pregnant at time of death 5 □ Other (specify)								World	Duy .cu.		
that the									obacco use	contribute to	the cause of death?		
quires nn sign	d by	1 Tes 2								res 2 🗆 1	No 3□ Pr	obably 4XI Unknown	
aw red as bee 2 shot	plete						*		24a. Was		24b. Were au	topsy findings available	
The late has page	Completed								perfo	rmed?	death?	,	
iclan; certific ector,	Be (25. Was case reference examiner?		Hospital:			Oth	26. Place of Dea	th (Check only o	ne)			
Phys r this ral dir	5									cify)			
th. th: Afte	tion	1 X Natural 2 ☐ Accident	5 Pending	g (Month, D	ay, Year)	Injury	Worl	ḱ? Yes 2∐No			rijury occurred		
r Atter	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could r determ	ined 28e. Place of Ir	jury - At hon tc. <i>(Specify)</i>	ne, farm, stre	eet, factory, office		28f. Location (S City or Tow		lumber or Ru	ıral Route Number,	
italou rrs aft ral Di								-					
To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)	2 Medical	Examiner: On the basis	of examination	on and/or inv	vestigation, in my o	opinion, death occu	rred at the time,	date and pla	ace, and due	to the cause(s)	
To the vithin to the comple	Med	29b. Signature and	title of certifier	and manner s	itatou.		29c. Licens	se number		29d. Date s	signed (Month	h, Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar State Registrar								Februar 19 2010					
31		30. Name and addr	ess of person	who completed cause of	death (Item	23a) (Type, I	Print)		1.	5.0	7	1	
ノ ・		Nobed Fein 31. Date filed (Mon.	berg 1	no 11165,5+	raffiele	d Cour	A 1St Floor	Marriott.	sville, ~	S as	1104		
Sta Registra		On Date med (IVIOTI	FEB 2:	3 2010	us j	8. A	arker						

DHMH 17 Rev 1/2001

10-01385 Sonia Marie Cobb Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

onia Marie Cobb	1- For State Certificate of Death									
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of De	ath	3. Time of Death						
edical Examiner	SONIA MARIE COBB	Month February	Day Year 15, 2010	1615 hrs						
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location		4c. County of Death							
	10301 Martin Luther King Highway Upper Marlboro		Prince George's							
Funeral	5 ()		Sirth(MM/DD/YYYY) 9. B Fore	rthplace (State or						
Director	219-08-8018 1 M 2x F 39 Yrs. Months Days Ho	ours Min. 4/12/	1970 °	gnCheverly,						
	Usual Residence of Decedent			Land to the one time.						
₩ any	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 🏋 Yes 2 No						
Maryland 28a-f show 1 at once. ector	Maryland White Plains	·····								
Maryland r 28a-f sho ed at once.	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	intry?						
r death with the Maryland or items 23a or 28a-f sh must be notified at once Funeral Director	10613 Riva Place 20695		United Stat							
th wit	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Control		Io- 14. Race - Ame White, etc.	rican Indian, Black,						
or it	1 Yes 2 X No	nif r	Specify: B1	ack						
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once sed by Funeral Director	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No spec 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Gi		16b. Kind of Business							
2 hour	Elementary/Secondary (0-12) College (1-4 or 5+)			····,						
36 hin 72 edical	12 2 Hair Stylist		Private							
215-0036 be filed within 72 hour mal Hygiene. rked other than "naturent, the Medical Exam Be Completed		ther's Name (First, Middle	kerson e Number, City or Town, State, Zip Code) ains, Maryland 20695 20c. Location - City or Town, State 10 Waldorf, Maryland eral Homes, P.A. stville, Maryland 20747 ry arrest, shock, or heart Approximate Interval							
215 be file ntal Hy rked o	Gayle Golding Par	tricia Wilke	rson							
21214 ould be fill d Mental F s marked tic event,	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N	Number or Rural Route No	umber, City or Town, Stat	e, Zip Code)						
MD 21215-0036 12 should be filed within 7 12 should be filed within 7 12 is marked other than maric event, the Medica	Charmaine D. Wilkerson /Daughter 10613 Riva Place		ns, Marylan	d 20695						
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	, Date	20c. Location - City of	r Town, State						
Baltimore, osmit Pages I an Ospatiment of Hea Ospatiment of Hea Important: If iter injury or other tra	4 Departion 5 Other Specify: Heritage Memorial	2/22/2010	Waldorf.	Maryland						
alti mit. partm ports ury o	21. Signature of Funeral Service Licensee 22. Name and Address of Fac	cilityPope Funer	al Homes, P	.A.						
E P P W	Charles E. There 15538 Marlboro	Pike Forest	ville. Marv	land 20747						
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a failure. List only one cause on each line.	as cardiac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and						
/Medical Examiner	Immediate Cause (Final disease a Multiple Injuries	····		Death						
	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): b. Due to (or as a consequence of): C. Due to (or as a consequence of):									
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6876(certificate rding physes as the b	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectr	topic pregnancy	Month	Day Year						
ox 68760 eath certificate I attending phys for use as the bu sician/Me	past 12 months? 4 Pregnant at time of death 5 Other (Specify)									
the death of the attentiched for us	1 Yes 2 No 9 Unknown 9 Unknown	Dad Jase Did	23e. Did tobacco use contribute to the cause of death?							
ires that the signed by be detach	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in		es 2 ✓ No 3 Pro							
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Sorce law re has be 2 sho			opsy prior to formed? death?	prior to completion of cause of						
Records, The law require ficate has been sig page 2 should bb		No 1 ✓ Yes 2 No								
of Vital Records, ng Physician: The law require of the this certificate has been sineral director, page 2 should be 1: To Be Completed	examiner? Other:	ath (Check only one)		. 0						
Physical dir	1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA United 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c Injury at W	Training Home 5	Residence 6 Other	er: Scene						
Sion of Attending P or death ector: After by the funera	1 Natural 5 Pending Feb 14, 2010 1700 hrs 1 Yes 2	Subject sh	ot							
ivision or Attent after death Director: I in by the	2 Accident Investigation Investigation 28e. Place of Injury - At home, farm, street, factory, office building	subjec	t was assau (Street and Number or B							
Division spital or Attendia hours after death neral Director: / filled in by the fi	State)	treet and Number or Rural Route Number, City ate) low Drive, Seat Pleasant , MD								
C fill	4 Homicide (Specify) Park/Recreation Area 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and									
To the Hospital within 24 hours: To the Funeral completely filled	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death	h occurred at the time, dat	e and place, and due to	he cause(s)						
To To Mec	29b. Signature and title of certifier 29c. License number	ber	29d. Date signed (M	onth, Day, Year)						
	Amiliarthull all		February 16, 20	10						
1:	30. Name and address of person who completed cause of death (Item 23a)									
4	Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Bal	ltimore, MD 21201								
State	31 Date filed (Month, Day, Year) 32. Relistrar's Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 00:30 2010 on le 02 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Randalls town tospita 8. Date of Birth (Month, Day, Year) 03/30/1961 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Funeral Days 1 □ M 2 屎 F Director 216-78-5154 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f shout the Midical Examiner must be notified at Director N/A1 ☐Yes 2 ☐ No MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2570 W. Lafayette Avenue 21216 U.S.A. Funeral death v 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3 Widowed 4 Divorced Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black Š Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7: h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service Mail Handler Year 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Conley Hawkins George ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a portant: If item 27 is / Injury or other trau 5002 Clifton Ave., Baltimore, MD 21207 Tracy Joyner (sister) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Joseph Brown F/H
and Crematory 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: # Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD umo Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 111 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical as 1 attending use IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy for 5 Other (specify) the 9 Unknow è is been signed to 2 should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has e 2 s autopsy page, certificate 2 No 1 □Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To After thi funeral of 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day, Year) Natural 2 Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

State

P.0.

Division of Vital Records,

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person w

essie

brough - 32, Registrar's Signature 5401 Old Court Rd, Randellstown, MD

Registrar

ath (Item 23a) (Type, Print)

29c. License number

068867

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Foh 1. Decedent's Name (First, Middle, Last) Day **Physician** ebruar 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 🗆 M 2 🗆 F June28,1955 MD 214 62 9110 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County 1 ¥ Yes 2 □ No ems 23a or 28a-f sh must be notified a n/a Baltimore MD Director 10g. Citizen of What Country? 10f. Zip-Code 0e. Street and Number 21205 402 N. Aisquith St. Apt.203 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. items 11. Marital Status 1 Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: black 2 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education other than "natu (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Cloverland _ 12th Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental H Laura Venable Bernard Carrington ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (brother) 127 S. High St. Balto, Md. 21202 Carlton Carrington Health 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
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Important; if ite
any injury or otl
once, 1 Removal from State OwingsMills,MD 2010 GarrisonForestVetCemMarch5, 4 ☐ Donation 5 ☐ Other (Specify) ignature of Funeral Service Licenses 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final 100 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 🗌 Ectopic pregnancy Live birth in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 Tes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tes 1 Tyes certificate 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Other: Hospital: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 Tes Inpatient မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred in by the funeral 27. Manner of Death Certification: Natural 2 Accident Injury Pending investigation 1 ☐ Yes 2 ☐ No death within 24 hours after deatl To the Funeral Director. 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion death. Hospital 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

FFR 2.3 2010

Leave 1. Begistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ment's 2076 2140 M MES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Arundel . Age (In yrs. last birthday) Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213-30-6759 1 **Z** M 2 □ F Months Days Hours Min. July I3 1933 Country) Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location with the Maryland Director Maryland 1 🗌 Yes 2 🖵 No Anne Arundel Pasadena 10e Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ıral", or items 23a or Examiner must be r Funeral 181 11th Street IISA death v 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ð 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", Completed Isround Mental Hygiene.
If is marked other than "natural manualic event, the Medical E. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 millwright Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည George Carey Carmita Winters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Carey daughter 181 11th Street Pasadena MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State Metro Crematory Inc. 2/22/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Maryland 21. Signatu 22. Name and Address of Facility Stallings Funeral Home P.A. Mountain Road Pasadena MD 21122 Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each time. to not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Day Year Pregnant at time of death signed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 🗌 No 1 Yes Yes 2 🗖 To the Hospital or Attending Physician: 25, Was case referred to medical director, To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this filled in by the funeral 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: Al completed filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner; to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifie

State

Registrar

10+1

Name and address of person

FEB 23 2010

31. Date filed (Month, Day, Year)

DEFENSE MIGHWAY

no completed cause of death (Item 23a) (Type

32. Registrar's

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- Andrews		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death										f Death	
	5370 Colonial Drive Chesapeake Beach Calvert												
Funeral		5. Social Security I		er 6. Sex 7. Age (In yrs. last birthday)			If Under 1 Y		e of Birth(f	MM/DD/YYYY)		hplace (State or	
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any		Usual Residence o	f Decedent 10b. County		10c Cit	ty, Town or Locat	ion						10.11.11.02.11.22
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th the Maryland 23a or 28a-f sho notified at once.	Director	5510 Co1	onial	Drive			20732					at Oodin	u y :
with ms 23.	uneral	11. Marital Status	11. Marital Status 12. Was Decedent Ever in U.				s Decedent of I	Hispanic Origir	n? (Specify Yes	or No-	USA 14. Race -	Americ	an Indian, Black,
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s after ral",	þ	3 Widowed		orced If Yes, Give Yes or Dates:			Yes 2X				Specify:	ify: White	
2 hour "natu	Completed	Elementary/Seco		cify only highest gra-		16a. Deceden during m	t's Usual Occup ost of working li	pation (Give kii ife. DO NOT u	nd of work done se retired)	16	b. Kind of Bus	iness/In	dustry
336 thin 7 re. than	nple	12		0	140131)	911	dispato	cher		Pı	rince G	eor	ges County
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Con	17. Father's Name	First, Middle,	Last)					Name (First, Mi			-	geb dodney
21215-0036 wild be filed within 7 Mental Hygiene, marked other than	Be	James The						Dona	Kathryn	Bake	er		
MD 21 2 should h and Me 27 is ma imatic ev	Z	19a. Informant's Na									per, City or Town, State, Zip Code)		
- P = E = R		Anna Klud 20a. Method of Disp		s/friend	20h	18 Pla	ntation	Dr; U	nit 106				FL 32760
Baltimore, permit. Pages 1 at Department of He Important: If ite		1 Burial 2	Cremation	3 Removal fr		crematory or oth		ernetery,	Date	20	c. Location - C	ity or i	own, State
드라이트니		4 X Donation 5		License		22 N							
Balti permit. Departm Imports injury o		21. A mature Fundral Service License 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Raltimore, Maryland 21201 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart									Street		
Physician		23a Part I. Enter th	e disease, or	complications that ca	aused the deat	h. Do not enter th	timore, e mode of dyin	Mary 1 g, such as card	and 212 diac or respirato	01 ry arrest, s	shock, or hear		Approximate Interval
/Medial Examiner		failure, List onl Immediate Cause (F	y one cause	on each line. a. <u>Propox</u>									Between Onset and Death
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Division of Vital Records, tal or Attending Physician: The law requirers after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be a perfer or the funeral director.	P P	examiner? 1 ✓ Yes 2	No	Hospital 1 Ir	patient 2	ER/Outpatient	F	Other	ursing Home 5	Resid	dence 6 🗸	Other: S	cene
n of ling P After funera		27 Manner of Death 1 Natural		28a. Date of (Month,	of Injury Day,Year)	28b. Time of Inj	·	ury at Work?		ribe how in	njury occurred		
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lospita f hour unera	ပ္ပို	4 Homicide 29a Certifier		(openi)							5510 Cr e Beach		
Divisior To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 V	ledical Exam	vsician: To the best niner:On the basis of	examination a	ge, death occurre ind/or investigatio	n, in my opinio	late and place, n, death occurr	and due to the red at the time,	cause(s) a date and p	and manner as lace, and due	stated to the c	ause(s)
To Viii	ğ.	29b. Signature and ti		and manner sta	ated		29c. Licens				Date signed		
		(Yes	Corle	ew)			O.C.	M.E.			bruary 12,		
	-	30 Name and address	s of person w	ho completed cause	of death (Item	23a)							
		Laron Locke		sistant Medical		111 Penn S	Street, Baltii	more, MD 2	21201				
Sta Registi		31 Date filed (Month,		32. Reg	istrar's Signatu	South							
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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01.994 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 2010 Michelle Darlene Chapman February 11:30 AM /Medical 4a. Facilify Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 400 Virginia Avenue; Apt 1A Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye March 18, Birthplace (State or Foreign Country) 5. Social Security Number Year) Hours 1 □ M 2 🖾 F Months: Days 219-66-2220 54 1955 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Hagerstown Washington Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 USA 400 Virginia Ave; Apt 1A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 X Married Specify: White 1 ☐Yes 2X No Specify. <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) credit card security First Data Credit Card 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles W. Young Katherine Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Virginia Ave; Apt 1B; Hagerstown, MD 21740 Denise Young/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Ronal of S. Wade 22. Name and Address of Facility
State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part 1 Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate use (Final disease or condition resulting in death Chronic Obstructive Pulmonary Due to (or as a consequence of): Abuse obacco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy Chronic vival Hepatitis C performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

requires that the death certificate be executed 68760, Vital of Hospital or Attending Division

Funeral

Director

show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modeal Exeminar in ust twe notified at

72 hours after

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Department of Health a Important: If item 27 is any Injury or other tra once.

Physician /Medical

Examiner

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24 hours a

within 24 hou To the Funel completely fil

29a. Certifier

29b. Signature

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

STEVEN BLASH MD



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

058810

Hagerstown

29d. Date signed (Month, Day, Year)

TEBRUARY 16 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hebruary Henry Eugene Carlson 20. 2010 9:40P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 704 Seagrove Road Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) (Month, Day, Year) une 18,1941 1 □XM 2 □ F Days Months 320-34-2273 Director 68 June Illinois Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MI Anne Arundel 1 Yes 2X No Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 704 Seagrove Road 21060 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1. X Yes 2 ☐ No Black, White, etc Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify. "natural", White 3 Divorced 4 Divorced Specify: Year or Dates r Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maritime Institute Elementary/Seconday (0-12) College (1-4 or 5+) System Administration of Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Glenn Carlson Mary Ellen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Margaret Carlson/ Wife 704 Seagrove Road Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot February 20c. Location - City or Town, State 1 🔣 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Cedar Hill Cemetery 4 Donation 5 Other (Specify) 24, 2010 Brooklyn Park, MD permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Crmeation Services PA 1 2nd Ave. SW Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final nset and Death Physician/ bladder disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year 4 ☐ Pregnant 9 ☐ Unknown ed by the a detached f g Unknown Division of Vital Records, P.O. the Hospital or Attending Physician; The law requires that the certificate has been signed lector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 Yes 2 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print)

The D Munium WD 225. Green St Bautim cre MD 21201 Name and address of

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#4b, perPHYS#10e, perFH, G900, 2/23/2010, WS

State of Maryland, Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ CARTER Day 4:55 P. M GERTRUde 20:0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARdwell AVE. 314 BALTO 4300 AFT. Nottingham 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth **Funeral** (Month Dayo Yar) 1 M 2 8 F Davs Hours Min 1930 Maryland 214-26-0197 Director Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 No MD Baltimore Nottingham 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21236 United States 4300 Cardwell Ave. Apt. 314 items 2 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit, Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) C & P Telephone Elementary/Seconday (0-12) College (1-4 or 5+) Office Clerk other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma Smith Pfarr Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1202 Apparition Lane Middle River, MD 21220 Kathy Minoglio /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dataeb 15 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) any injury or Beltsville, Maryland 2010 Chesapeake Crematory 22. Nar Campation Family Funeral Alternatives 21. Signature of Funeral Service Licensee 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiopul disease or condition Medical resulting in death) Examiner Theroscle Sequentially list conditions, Examine Due to (or as a consequence of) it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and -transit The law requires that the death certificate be executed 1 abetes Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Tetal death in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death Yes 2 Jun detached g Unknown P.O. 1 by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed k 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 1 3 Probably 4 Unknown Records, icate has been siç ; page 2 should b Completed 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 prior to completion of cause of certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 10 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred Certificate: work? 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) losmus Hans 0061480 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 10 V State FEB 23 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Olico AM 2010 EBROLARY <u>Homer Burke Carr</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sep. 19, 1 9. Birthplace (State or Foreign **Funeral** Days 1 🛛 M 2 🗆 F Hours Country) Yrs. **Director** 218-18-7921 86 Maryland Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits notified at Director 1 Yes 2 No Maryland Harford Bel Air 10f. Zip Code ö 10e. Street and Number 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funeral 111 Highland Road 21014 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ş 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry within 72 h (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Industrial Elementary/Seconday (0-12) College (1-4 or 5+) Service Manager Instrumentation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o ည Leta Louverta Bowers Homer Heatwell Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sof Health Betty Jean Carr / Wife P.O. Box 592, Bel Air, Maryland 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State artment of I permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2-24-10 Fallston, Maryland <u>Highview Mem. Gdns</u> of Funeral Sar 22 Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death CERE BROVASCULAR THROM BOSIS Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year ed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signed to should be det 23e. Did tobacco use contribute to the cause of death? þ FIBRILLATION Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 5 Pending Natural 1 Yes Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gretifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day Year) 29b. Signature and title of ceftifie 29c. License number

State
Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

She

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State Registrar	State of Ma		ertificate of I		F	Reg. No	2010	04998	
Physic		1. Decedent's Name (First, Middle, Las	t)	\mathcal{C}	hilds		2. Date of Dea	Day	? Year 2010	3. Time of Death	
/Medi Exami		4a. Facility Name (If not institution, give				r Location of Death	h	4c. C	County of Death		
		The Johns Hopkins H 5. Social Security Number 6. S		(In yrs. last birthda)	Baltimore If Under 1 Year	City If Under 24 Hrs	8. Date of Birt	N/A of Birth 9. Birthplace (State o.			
Funeral Director		220-30-3055 1 XM 2 D F 93 Yrs. Months Days Hours Min. (Month, Day, Yea								inois	
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Ba-f sliffed	Director	Maryland N/A	Baltimor							1 X Yes 2 □ No	
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eath v	Funeral	1019 Winding Way	12. Was Decedent Ever in U.S. 13. W		B. Was Decedent of H if Yes, specify Cub:	21210 Hispanic Origin? (S	Specify Yes or No-	U.S., s or No- 14. Race - Ar			
lore, Maryland Z1Z13-UU30 ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates: W	0	If Yes, specify Cub	an, Mexican, Puert	to Rican, etc.)		Black, White, e		
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Taryla 2 should and Merriss marker aumatic e	1	19a. Informant's Name/Relationship (1	Type. Print)	19b. Ma	iling Address (Street	t and Number or R	tural Route Numbi	er, City or	Town, State, Zip	Code)	
e, R 1 and 2 Health em 27 i		Dr. Ann E. Pulver	(wife)		Winding	Way Bal	timore,		Land 21 sation - City or To	210	
		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi	Removal from State	Green Mo	position (Name of ematory or other plan ount Crema	atory 2-	20-10	Balt	imore,_N	· =	
Darri permit. Departn Importa any inju		21. Signature of Funeral Service Licens		l	22. Name and Addre	ess of Facility Viedefeld	l Funeral	. Hom	e, Inc.	04.04.0	
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Dhusisian	à 1	shock, or heart failure. List only of Immediate Cause (Final	one cause on each line	Diratar	V for	lura,				Interval Between Onset and Death	
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VITAI cian: T ertificate ector, p	Be (25. Was case referred to medical examiner?	Licenitet + #		104	26. Place of De	ath (Check only o	ne)			
OT VITA Physician: this certific aral director,	မ	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatier		ent 3 1 DOA	4 🗆 Nursing r	Home 5 Resid			0	
On Alling F. After t	tion	1 Natural 5 ☐ Pending	(Month, Day		y Wo	rk?] Yes 2 🗌 No					
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2	Certification:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, strubulding, etc. (Specify)			street, factory, office		28f. Location (City or Tow		Number or Rura	al Route Number,	
the Hospital hin 24 hours the Funeral mpletely filled	edical C	29a. Certifier 1 A CertifyIng Ph (check only one) 2 Medical Exar	ath occurred at the ti investigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner as s place, and due	itated. to the cause(s)			
To the vithin	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date	signed (Month,	Day, Year)	
		1 Kuhn			RE	3-000		Febr	very 18	3,2010	
		30. Name and address o person who	1		e, Print)	600	North 14/-				
	ate	31. Date filed (Month, Day, Year)	reenbero 32. Registrar			600	NOTIN WO	me St	, palumoi	re, MD, 21287	
Regist	ate rar	FEB 2 3 2010		B. Aga	Med						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Duncan 845 AM Bettu February 0105 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Seasons Hospice @ Northwest Hospital Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Dec 6, 1934 9. Birthplace (State or Foreign Country)
New York **Funeral** Hours Days 1 □ M 2 🕅 F 120-26-8294 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 23a or 28a-f show Examiner must be notified at 1X Yes 2 □ No Director Baltimore Maryland N/A 10e. Street and Number 10g. Citizen of What Country? 10f Zip Code 1908 Breitwert Avenue 21230 USA Pages 1 and 2 should be filed within 72 hours after death Funeral items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Yes 2 ሺ No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 o, Specify: White 1 ☐ Yes 2X No þ 3 Widowed 4 Divorced 'naturai", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Me Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien. Important: If Item 27 Is marked other tha any Injury or other traumatic event, the 1 once. Clerk Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Fraver Howard J. Wright 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William Duncan, Son 5570 Oakland Road Halethorpe, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. | 02/22/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licence Thomas Gregor Remarkable Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cor Physician Pulmona disease or condition resulting in death) /Medical Due to (or as a co sequence of): Examiner Palmonary honic Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Completed by Physician/Medical as attending p IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for ☐Yes 2☑No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy performed? 1☐ Yes 2 X No or Attending Physician: director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation (Month, Day Year) 1 TNatural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospital 29a. Certifier Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 0053337 20,2010

State Registrar 31. Date filed (Month, Day, Year) FFR 2.3 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835



Smith

Hvenue

Suite 203

10-01455 Arthur Deems Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar_	ate of Maryland	•	ate of Death	and Mich	,,,	teg. No.	0 05001		
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legical Examine	4a. Facility Name (if not institution	on, give street and number)	February f Death	18, 2010 4c. County of Deal						
	4709 Shamrock Aven	ue		Baltimo	re					
Funeral Director	5. Social Security Number—Unit 6. Sex 7. Age (In yrs. last birthday) 15. Months Days Hours Min. Dec 23, 1955 Maryland									
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O & E T	Mary Leon/Sist	eno/BCPD	1	559 Kingsto 900 Argonn	on Rd.	Baltimore,	mber, City or Town, State Maryland 2	1220 0000)		
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Baltimory permit. Pages I Department of I Important: II injury or other	21. Signature of Funeral Service Port and S	Licensee Waste, Tire	ctor	22. Name and Add	ess of Facility	Connelly	Funeral Hor W. Baltimo	ne of Essex re Street		
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f Vital Physician: or this certi	examiner? 1 Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/0	utpatient 3 DOA	Othor	Nursing Home 5	Residence 6 🗸 Othe	er: Scene		
_ = ≝ . ₹ 2 2		28a. Date of Inju (Month, Day,Y	ry 28b. ¹ ear)		njury at Work		how injury occurred			
Division tal or Attendi rs after death. al Director: /	2 Accident Inve	stigation 28e Place of In	jury - At home, fa	irm, street, factory, offic			Street and Number or R	ural Route Number, City		
Division of Vital Bospital or Attending Physician: 44 hours after death and proceed to the process of the pro	Suicide 6 Cou	Id not be (Specify)				or Town,				
Division Division To the Bospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	(Check only 1 Certifying F	hysiclan: To the best of multiple the high multiple that the basis of example the high multiple that the high mult								
To the within To the compl	29b. Signature and title of certifi	and manner stated.			ense number		29d. Date signed (M			
	Lelal	enie)		0.	C.M.E.		February 18, 20	10		
	30. Name and address of person	·	,	Donn Street Pa	ltimore MA	7 21201				
Stat		Assistant Medical Exa		Penn Street, Ba	minore, Mi	J Z 1ZU I		_		
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